Sida Evaluation 2008:03

# Phasing-out Swedish Health Support in Luanda, Angola

## A Study of the Evolution of Reproductive and Child Health Services, 2006–2007

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Department for Democracy and Social Development

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# Acronyms and Abbreviations

| | |
|---|---|
| Asdi | Agência Sueca para o Desenvolvimento Internacional (Portuguese for Sida) |
| BCG | Vaccine against Tuberculosis (Bacille de Calmette et Guérin) |
| CAOL | Coordenação de Atenimento Obstétrico em Luanda (Coordination of Obstetric Treatment in Luanda) |
| CAPEL | Coordenação de Atendimento Pediátrico de Luanda (Coordination of Paediatric Care in Luanda) |
| CEP | Curso Especializado de Parteiras (Course for Specialization of Midwives) |
| DPSL | Direcção Provincial de Saúde de Luanda (Provincial Directorate of Health of Luanda) |
| DTP | Vaccine against Diphteria, Pertussis (Whooping Cough), Tetanus |
| EC | European Commission |
| EDP | Essential Drugs Programme |
| EU | European Union |
| EPI | Extended Programme of Immunization |
| GNI | Gross National Income |
| HIV/AIDS | Human Immune Deficiency Vírus/Acquired Immune Deficiency Syndrome |
| IMCI | Integrated Management of Childhood Illness |
| IMF | International Monetary Fund |
| IUD | Intra Uterine Device |
| INE | Instituto Nacional de Estatística (National Institute of Statistics) |
| Kz | Kwanza, Angolan monetary unit |
| MCH | Mother and Child Health |
| MINSA | Ministério da Saúde (Ministry of Health) |
| MMRi | Maternal Mortality Ratio-institutional/intrahospital |
| MoF | Ministry of Finance |
| MoH | Ministry of Health |
| OMA | Organização da Mulher Angolana (Angolan Women's Organization) |
| PAI | Projecto de Apoio Institucional (Institutional Support Project) |
| PHC | Primary Health Care |
| Sida | Swedish International Development Cooperation Agency |
| STD | Sexually Transmitted Disease |
| TBA | Traditional Birth Attendant |
| ToR | Terms of Reference |
| WHO | World Health Organisation |
| WTO | World Trade Organization |

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Special thanks go to the staff at the Provincial Directorate of Health in Luanda, who have provided us with information and shared their own views with us in an open and friendly discussion. We also want to include all the health workers we have met during our field trips who have enriched our understanding of the often very trying reality they are facing in their daily work.

*Kajsa Pehrsson* *Kenneth Challis* *Tazi Maghema*

# Executive Summary

## Introduction

This evaluation can be seen as a complement to the broader study *Healthy Support? A Study of Sida's Support to the Health Sector in Angola 1977–2006*, since it has a specific focus on the phasing-out of the last remaining programme components with Swedish support.

The aim of the evaluation is to study the phasing-out process *a posteriori* and its effects on the sustainability of the MCH programme in Luanda province. The report concentrates on the development within the MCH sub-sector and service delivery after the phasing-out period. We summarize our findings and conclusions one year after the end of Swedish support and present some recommendations that hopefully are of relevance to both parties.

The evaluation was organized in three steps and the Swedish team members visited Luanda in April and November 2006, and finally in April 2007. In Luanda the team worked together with an Angola Public Health specialist, Dr. Tazi Maghema.

The main source of information is the series of interviews with Angolan decision-makers at the Provincial Directorate of Health of Luanda (DPSL) and a large number of health staff at Hospitals and Health Centres.

At the first visit, the team tried to isolate some key issues to be analysed. A set of indicators was defined to try measuring success, setbacks and sustainability of the MCH system.

## Programme Components

*Reproductive health*

The dramatically high maternal mortality in the biggest maternity hospital in Luanda served as an eye-opener to Sida and motivated maternal health as a new programme component in the broader support to the Health Sector. From 1989, the support was initially directed to the coordination body CAOL (Coordination of Obstetric Treatment in Luanda) which was created in 1990 within the (then) Provincial Health Delegation of Luanda.

CAOL's main aim was to clarify the roles of the health units and levels of the reproductive health system and, gradually, to reform the centralized and ill-functioning system. It was equally supposed to develop methods for improved management of the maternal health care.

The basic reform was the building and equipping of delivery rooms at Health Centres in the nine districts of the province. The idea was to establish small maternities in the suburban areas where the majority of the population live, and through such a measure increase the number of institutional deliveries under safe conditions. These services should also unburden the specialized maternity hospitals in central Luanda, which were extremely crowded and, ironically, mainly occupied by normal deliveries. With the time, maternal health became reproductive health, thus including family planning services, and, more recently, counselling and treatment of HIV infected pregnant women and their new-born children.

*Childrens' health*

CAPEL (Coordination of Paediatric Treatment in Luanda) was created in the mid-1990's to improve the service provision of the child health sub-sector Luanda. CAPEL was inspired by the CAOL model, since problems were partly the same as for maternal health. There was a need to decentralize paediatric services through creating emergency wards in the suburban districts and to improve the quality of child health services in general.

The main objective of the child health project was to combat infant and child mortality, to improve child health in general and, logically, to improve and strengthen the child health care. With paediatric units at suburban Health Centres parents could reach medical services closer to home. The building up of a functioning referral system was also an important objective, to help unburden the national Paediatric Hospital David Bernardino in the city which was receiving hundreds of children per day with symptoms that did not need specialized care.

CAPEL got financial support s well as technical assistance – but less than CAOL – to implement training of staff, and to make general improvements of services at all levels.

*Training of midwives*

The Course for Specialization of Midwives (CEP) started in 1998, and received funding from Sida from the beginning as well as technical assistance. Students have been recruited from Luanda and other provinces. The fourth course was concluded in the end of April 2006. During the phasing-out period, work started with the establishing of two new midwifery schools in Malanje and Huíla provinces, to expand this training facility to other regions where there is an urgent need for trained midwives.

From the beginning of 2004, the school has been totally funded by the Human Resources Department of the Ministry of Health. The midwifery school has not had any technical assistance during the phasing-out period.

*Institutional support*

The Institutional Support Project (PAI) at the time of phasing-out of the programme. It was based at DPSL and was mainly a channel for major investments during the phasing-out period.

The project aimed at expanding and strengthening the health system in Luanda province, and, simultaneously, integrating the different projects within DPSL through defining their field of activities. The implementation of the strategy for Improvement of Quality in Primary Health Care was another key element, which has been supported by the project. Among the areas of intervention were the following:

- health work at community level
- staff training – planning and management
- development of the referral system, and
- laboratories and bio-security

## The phasing-out process

*Decision to terminate cooperation*

In 2003 the Swedish government and Sida decided to terminate the support to MCH in Luanda. This was based on the analysis made by Sida's Africa department and the Ministry of Foreign Affairs. The Country strategy 2003 underlines not only the great insecurity regarding Angola's development policy but also the lack of transparency of the state financial situation. All other bilateral cooperation

programmes had already come to an end and it was not considered motivated to continue a long-term bilateral development programme in the health sector. In addition, the country's rich natural resources could be used for reconstruction and social development after the end of the civil war in 2002.

The decision to phase out the support to Mother and Child Health in Luanda came as a surprise for Sida's Health Division and, naturally, for the Angolan party. A final agreement for the phasing-out period was elaborated and planned to take effect 1 January, 2004. Due to the results of an audit report late 2003, Sida decided to withhold the disbursement of funds for the programme and signing of the final agreement was delayed until 31 May, 2004.

*Objectives for the phasing-out period*

The main objective of Angola's Health project 2004–2005, was "to contribute to a better health for the mothers and children who live in Luanda province". The quality of the existing services needed improvement, as well as knowledge and competence of health staff. Planning and management capacity at the Provincial Directorate of Health, at the district Health Sections, and at the suburban Health Units, needed to be strengthened, thus assuring the sustainability of the health activities.

The Swedish party equally underlines the future sustainability of the reproductive and child health services in the province. Since several major investments were included in the programme, the agreement states that the maintenance of these investments must be assured through the DPSL budget for recurrent expenses.

## Findings

*Activities 2004–2006*

The team could verify that day-to-day activities of all projects had been going on normally during the phasing-out period, with the exception for the first part of 2004 when funds were frozen in, and three months in the beginning of 2005 when all resources of the health sector were mobilized to combat the Marburg fever epidemic. The special training of staff from the reproductive and child health projects, courses/workshops in logistics and maintenance of vehicles, etc. had been implemented according to plans. Extra purchases of drugs and equipment were undertaken, as for example five ambulances that had not yet been delivered at the moment of the first visit in April 2006.

*Health budget for Luanda*

In 2006, it was practically impossible to get a precise information about the provincial health budget, and all interviews at Health Centres showed a rather desperate financial situation. All means and methods were used to guarantee the provision of services to the population. During 2006 Health Centres had no budget for running costs, and the main contribution from the provincial government through DPSL was the payment of health workers' salaries. These remain low, although a salary reform has been elaborated but not yet implemented. Salaries are still paid with a delay of one or several months, and this continues causing problems among health staff as well as among patients, since such a situation makes it difficult to eradicate the *gasosas* system, i.e. the illegal fees that patients are forced to pay to be attended although primary health care should be free according to law.

During 2006, both DPSL management and Hospital and Health Centre directors were expecting a decentralized budget at least from 2007 but there was no specific information on when and how such a reform should be implemented. In 2007, however, the budget reform had, amazingly enough, been launched and funds were decentralized to the district administration level, where the Health Centres belong. This can be seen as the main factor to guarantee sustainability of the decentralized MCH service, with its small peripheral maternity wards and child health emergency units.

*Institutional sustainability*

During a long period CAOL and CAPEL were functioning as projects on the side of DPSL, which was a risk factor from the sustainability point of view. Since April 2006, these projects no longer exist, but remain as coordination bodies within DPSL. The former CAOL and CAPEL coordinators are continuing their tasks within DPSL. Compared to the somewhat stressed situation in April 2006, just after the ending of the Swedish support, our impression one year later is quite positive, since activities are running at DPSL in a perfectly normalized way.

Since 2004, the midwifery course CEP continues with funding from the Department for Human Resources of the Ministry of Health and is part of the reorganized vocational training institution Luanda Technical Vocational Health School. The CEP course has never been the responsibility of the Provincial Health Directorate, but was developed within the scope of the support to maternal health and the efforts to reduce maternal mortality in the province.

*Service delivery*

Given the questionable quality of data, it is not possible to give a precise number of deliveries in Luanda. It goes without saying that there are no reliable figures on domestic deliveries, since families do not always register their children immediately after birth. Infant deaths might also occur without being recorded. From the recent statistics compiled by DPSL we can, however, conclude that institutional deliveries have increased considerably during a six years' period, although it seems like the number of deliveries at the Health Centres has gone down.

The information collected during the field visits make us confirm that the Health Centre delivery wards are clearly underutilized in spite of the population increase in the province. We have, however, no real explanation for this development. There is no particular negative trend in the quality of care, so one possible reason can be the prices charged at the Health Units, the *gasosas*, which we have confirmed in several cases. Another reason is, of course, access in terms of distance and transport.

*Maternal mortality*

The rationale for supporting maternal health in Luanda was the promotion of safe deliveries as a means of bringing down the maternal mortality in domestic as well as institutional deliveries. When support to CAOL started in the beginning of the 1990's the intrahospital Maternal Mortality Ratio (MMRi) was estimated to 1,010 per 100,000 live births at the two big maternity hospitals in Luanda (1991). The overall objective defined by CAOL was to reduce MMRi to 400 per 100,000 live births. From the data we have collected, it is clear that MMRi in Luanda has been reduced since the early 1990's, but the number of recorded maternal deaths is still extremely high.

One of the main problems through the years has been to reduce maternal mortality at the 1st level referral hospitals. The most important measure identified was to reverse the situation at the big hospitals, so that they, instead of receiving a majority of normal deliveries should concentrate on taking care of the high-risk deliveries. This evolution has been very slow, partly because these two hospitals are located in the city and are under pressure from a big part of the Luanda population.

*Antenatal care and family planning*

Investment in antenatal care and family planning was one of the initial strategies to improve maternal health and reduce maternal mortality. According to available statistics, the number of antenatal consultations has increased annually, but coverage is still too low.

Family planning services are working at all visited Health Centres. The number of visits has, however, declined but there is no clear explanation of that fact. People who work with reproductive health mean that attitudes among the Angolan people are extremely pro-natalistic, which is also reflected in the very

high population growth. According to a statistical survey 2003, the fertility rate is, on average, 7 live born children per woman.

*Child health*

If one can say that the peripheral delivery wards are still underutilized, this is certainly not the case of the paediatric wards at the Health Centres. They are supposed to function as emergency wards, open 24 hours per day, and they are usually very crowded. Paediatric health services are the most used of all, simply because children often get sick – malaria, respiratory infections and diarrhoea are the most frequent diseases.

In its annual report 2006 DPSL estimates the population 0–14 years at 2,825,000. Young children aged 1–4 years dominate at the paediatric wards, while the children <1 year are taken to the Health Centre for checking of weight, immunization, etc.

Paediatric care, as well as the rest of the health system, is managed mainly by nurses (female and male). During the existence of the CAPEL project quite a big effort has been made to train nurses according to the programme for Integrated Management of Childhood Illness (IMCI) and today there is a staff of well-trained paediatric nurses spread on the Health Centres in the province.

## Conclusions one year after phasing-out

*DPSL performing with responsibility*

A main conclusion, and a very positive one, is that DPSL has taken its responsibility to continue the work to defend the achievements made during the more than ten years with CAOL and CAPEL and the Swedish support. More resources for health services than ever are, in fact, available today. Services have not broken down, rather on the contrary.

*Integration*

The former projects CAOL and CAPEL have been successfully (re-)integrated into the DPSL structure. Instead of partly functioning as separate bodies, their staff and resources are, again, part of the PHC programme with its sub-programme MCH. This means that the positive effects of the long-project period, with capacity building, professional training of crucial staff categories, quality monitoring and supervision, attitude influence, etc. are not disappearing, but are assets that can have an impact on all health units in the province.

*Budget reform – a major achievement*

Since the Angolan party had agreed to assure the sustainability of the programme after termination of the external support, the phasing-out period was full of uncertainty. The responsible organ DPSL and its Director did not succeed in its negotiations in 2005 to guarantee resources from the Province Government, and during 2006 there was still no response from the government regarding a decentralized budget to avoid a degradation of the relatively well-functioning MCH activities. The budget reform in 2007 is therefore the most important contribution to institutional sustainability.

*Sustainability in a longer perspective*

Although we are rather impressed by the development within the MCH sub-sector, it is too early to judge whether the DPSL will be able to continue developing the access to and quality of health services in general and MCH services in particular. A continued positive development will need strong political support so that resources can be guaranteed to the most densely populated province in the country. But strengthened management capacity is also needed to implement the urgently needed reforms.

*Too short notice, too short phasing-out period*

The Swedish decision – by the Ministry of Foreign Affairs and Sida – to bring the support to MCH in Luanda to an end seems rather improvised and neither well founded nor well planned and only few people at high posts in Luanda were fully informed.

We believe that DPSL has succeeded in coping with the change of scenario and been able to shoulder the responsibility to take back the former projects into the organization. This has happened against the odds, since phasing-out was announced at very short notice and was planned to be finished after only two years.

*Was phasing-out a right move?*

Although we have concluded that MCH in Luanda has not collapsed after the withdrawal of the Swedish financial support and technical assistance, we want to raise the question whether it was at all justified to terminate this programme. Several factors indicate that cooperation could have continued, possibly in modified forms and under DPSL's leadership, especially since working conditions have improved after peace was established in 2002 and the basis for cooperation in many ways changed for the better. We have not found any traces of a dialogue between the parties or an analysis of pros and contras regarding continued support and/or phasing-out, which makes this decision appear very little facts-based and objective.

## Recommendations – to Sida

- An earnest recommendation to Sida and the Swedish government is to *resume support* to MCH in Angola within the scope of the so-called 'selective cooperation'. Objectives and goals should be identified and thoroughly analysed by the Angolan party, which is currently well aware of the resources on the Swedish side.
- Swedish development cooperation has limited experience of phasing-out and finishing programmes/projects. There are, however, a few examples that can be studied. One lesson is that *phasing-out takes time*. In this case Sida had no well-grounded phasing-out strategy and when, finally, the planning procedure could start in Luanda after several months of delay, it became more oriented towards the spending of the agreed budget and less towards an analysis of the post-cooperation situation. It is, therefore, strongly recommended to learn a lesson from this case and from earlier cases in development cooperation history. Sida needs to *analyse its phasing-out methods* to create guidelines for handling phasing-out situations, whether they happen under controlled conditions or in emergency situations.
- The Swedish motive for phasing-out the bilateral cooperation with Angola seems to have been purely political. Even so, the Swedish party should have needed to make some *self reflection* to analyse the frustrations behind the decision and look back at the almost three decades of bilateral cooperation with Angola. These years were filled with setbacks, and the main goals were not achieved. The experience was never thoroughly analysed by Sida, but seems nevertheless to have influenced the decision to finally withdraw also from the MCH sub-sector where results eventually have been rather positive considering the adverse conditions. There are, thus, reasons for Sida to analyse its own role in Angola, and such a reflection belongs to any decision of withdrawal from a long cooperation partnership. It should also be brought up for discussion with the respective government so that motives can be understood – and openly questioned – by the other party.

## Recommendations – to DPSL

- To avoid *information gaps*, and facilitate the management of the decentralized system, better contacts must be established and relevant documentation elaborated (manuals, regular newsletters, etc.). Responsible staff at DPSL have to control that information, e.g. on budgets and administrative issues, are passed from the District Health Section to the Health Units. Recurrent management training will be needed to strengthen the district level, and District Health Sections as well as Health Units need computers and adherent training to be able to perform according to their new responsibilities.

- *Health staff with specialized training*, e.g. in paediatrics, is moved internally to other areas so that their competence can no longer be utilized by the MCH programme. It is strongly recommended to avoid such measures, to make specialized staff continue working in the field where their professional skills can make a difference.

- With the extreme pressure on some parts of the health system, e.g. paediatric wards at all levels and the big maternity hospitals, it will take generations before the health system in Luanda will be able to respond to the needs of the citizens. More *investment in prevention* will therefore be needed as an immediate measure. The immunization programme does not reach all children and pregnant women, and it is therefore important that DPSL elaborates new methods for reaching out to the communities. *Health education* with mobile teams and informal and attractive communication techniques need to be introduced. It goes without saying that other languages than Portuguese have to be used according to the audiences. Collaboration should be established with civil society organizations to reach people in their local communities.

- Economic obstacles, such as *gasosas* and selling of essential drugs, gloves, etc., function as effective barriers for the poor to use available services and must thus be taken seriously by DPSL. It is not enough to create norms and rules; a system of sanctions must be established, enforced and monitored and not only staff, but also users should be informed about it. It must be broadly publicized that antenatal care and safe delivery, as well as health care for children, are rights which are free of charge.

- The distribution and control of *life-saving drugs*, e.g. oxytocin, antibiotics, hemacel, diazepam, etc., must be analysed by the MCH section of DPSL, since it is evident that these drugs are relatively often lacking in delivery rooms or exist in too limited quantity. This can be an information problem since some Health Centre staff allege not understanding why supplies do not arrive, and only know that CAOL and CAPEL have ceased existing. Regular control of stocks of disposables is needed, to avoid shortage or to reallocate disposables (or drugs) between Health Units.

- *An urgent need for safe deliveries is a blood bank* to serve all the Hospitals. This is one of the most serious matters that must be analysed and solved urgently by DPSL in collaboration with the Ministry of Health and the National Blood Centre. All Hospitals must have a permanent supply of blood, since transport of blood is not realistic considering the chaotic traffic situation in Luanda. Other life-saving factors are ambulances and *radio communication*. Ambulances must be kept in order and the *radio communication* system re-established to make the referral system function.

- It is strongly recommended to implement *regular maternal death audits* at all the maternity hospitals. These audits should be led by a senior and respected Angolan obstetrician, who should also be instrumental in developing strategies for the Luanda province to combat the high intrahospital maternal mortality.

- The complex issue of *abortion* should be addressed and somehow included in reproductive health. Illegal abortions still contribute to maternal deaths. A potent abortifacient drug is openly sold in Luanda, which does not normally kill a pregnant woman. But other methods do and hospitals daily receive young women who have tried to make an abortion. There is an urgent need to develop a

strategy to handle abortion as a reproductive health problem. Family planning services need strengthening, sex education is needed in schools and, finally, a liberalized attitude towards abortion when there is a need for it.

- During quite some time, UNICEF and CAOL were identifying and training so-called *traditional midwives*. The training was short and very elementary, mainly teaching how to identify obstetric risk cases and to improve hygienic conditions during domestic deliveries. Today the MCH programme has no organized contacts with the traditional midwives in the province. CEP now and then invites them to the course, to learn from them and to give them some basic lessons. Since these thousands of women who do not come to the delivery wards are usually assisted by another woman during childbirth, time has come to reach the traditional midwifes and bring them into the system. It is thus recommended that DPSL's MCH programme makes an inventory of active traditional midwives in the province and starts a dialogue to identify their capacity as well as their training needs. They can be an important link between the community and the health services. These women can equally be helpful with information about the characteristics and outcomes of home deliveries, and, above all, about women's preferences.

- *HIV-testing and counselling* need to be strengthened so that more women and their partners can be tested through the maternal health structures. ARV treatment of HIV infected women, men and children must be a human right and all citizens need to understand this. This is the only attitude which can help bring down the HIV prevalence in a long-term perspective. Safe-sex-messages must be a top issue at Health Units that work with family planning and sex education for adolescents. The health system cannot work with blinkers, in a situation where sexual behaviour is rapidly changing among urban youth, prostitution is growing dramatically and sex education in schools is very poor or non-existent.

- Also *family planning* should be a human right, based on a humane attitude. Since numbers of FP visits are going down, the issue has to be thoroughly analysed by DPSL to find methods of communicating the message so that new groups can be reached. So-called 'family planning' must be reformulated into reproductive health and be seen as one of several measures that will ensure greater maternal survival.

- Since the lack of *maintenance and repair* of ambulances, other vehicles and all kinds of medical equipment is one of the biggest problems identified by the Health Units, and really one of the causes contributing to the lamentable numbers of maternal and child deaths, DPSL has to take a real firm grasp of the situation. Either the DPSL sees to it that its maintenance team starts functioning with a group of professionally competent mechanics that can circulate regularly among the Health Units, or each Health Unit must have a generous budget to solve the maintenance problem with the help of local garages or other firms.

- For all purposes – theoretical and practical – the *quality of the statistics* of the health system needs an urgent improvement. It will not be possible for DPSL to follow budget utilization or even to make the simplest analysis of the productivity of the health system based on a cost/case/treatment estimate. The quality of provincial statistics, thus, goes together with the budget reform. This should motivate the recruitment of more statisticians to the Planning department at DPSL and, in addition, a well planned staff training at the Health Units, e.g. organized in collaboration with the National Institute of Statistics.

  Statistical reports are not only a working tool for the central level (DPSL) but also for the Health Units. It serves as feedback and information about trends of service delivery, etc. within the system. The DPSL report for 2006 is an ambitious and partly quite interesting publication. In the future, this kind of report should be edited in a way that makes it accessible to a broader audience and not only

to the top decision makers. It should be widely spread to health staff, NGOs and other civil society groups, the media, etc. The public administration has an obligation towards the citizens to supply reliable information regarding the health situation and service delivery in the province and to answer questions from the grassroots.

# 1. Introduction

The Swedish government through Sida – Swedish International Development Cooperation Agency – has supported the health sector in Angola for almost thirty years. Initially the programme had a national and multifaceted scope, but since the beginning of the 1990's, when the civil war once again flared up after the elections in 1992, it was agreed to narrow down the programme and concentrate on Maternal and Child Health (MCH) and training of midwives in the Luanda province.

A study of Sida's comprehensive support to the health sector 1977–2006 was undertaken in 2006 *(Pehrsson et al., Healthy Support? A Study of Sida's Support to the Health Sector in Angola 1977–2006)*. This evaluation can, thus, be seen as a complement to the broader study, since it has a specific focus on the phasing-out of the last remaining programme components involving Swedish support[1].

The phasing-out took place during a two years' period covered by the last specific agreement between Sida and the Angolan Ministry of Health (MoH)[2]. After an audit of the health programme in October/November 2003 Sida decided to postpone the signing of the specific agreement which was supposed to come into effect from 1st January 2004, and withhold the disbursement of funds for the ongoing programme. This led to an almost standstill of the programme, except for the Course for Specialization of Midwives *(Curso de Especialização de Parteiras/CEP)*, which was able to continue its activities thanks to active support from the Department of Human Resources and funding from the Ministry of Health.

The agreement was finally signed on May 31, 2004. As a consequence, the phasing-out period started 1 June 2004, and was supposed to terminate 31 December 2005. The contract with the Swedish implementing consultancy firm InDevelop[3] was signed for the same period (8 June 2004–31 December 2005).

# 2. Purpose and Scope of the Evaluation

This evaluation concentrates less on the process of phasing-out but on its possible effects on the sustainability of the institutions and health components supported by Sida. (For Terms of Reference/ToR, please refer to *Appendix 1.)* The report describes actions on the Swedish as well as the Angolan side, and concentrates on the development within the MCH sub-sector and service delivery during and after the phasing-out period. We summarize the information gathered by the team and include our findings and conclusions one year after the end of the Swedish support. We finally present some recommendations that hopefully are of relevance to both parties.

[1] The intention of the Swedish government to terminate development cooperation with Angola was communicated at high-level meetings in Luanda in June 2004.

[2] Since July 1999, there was no general agreement on bilateral cooperation between the Angolan and Swedish governments.

[3] InDevelop was contracted by Sida to implement the health sector programme in 1995.

# 3. Method and Limitations

## 3.1 The Team

The team is composed of three consultants. The team leader, Ms. Kajsa Pehrsson, is an experienced evaluator with several assignments in Angola and other African countries. The obstetrician Dr. Kenneth Challis, has equally a broad experience from developing countries, and participated in an evaluation of the MCH programme commissioned by Sida undertaken in 2003. In Luanda, the Swedish team members worked together with Dr. Tazi Maghema, an Angolan Public Health specialist. The Swedish consultants are both fluent in Portuguese.

## 3.2 Methodological Issues

The evaluation was organized in three steps[4], i.e. with three field visits:

- 4–11 of April 2006, shortly after the end of the Swedish support;
- 24–29 November 2006, and
- 18–25 April 2007, i.e. practically one year after the end of Sida's support to MCH in Luanda.

The team got access to the most recent documents regarding the projects, such as project documents and annual reports, but there was very little documentation on the phasing-out process as such besides the Country Strategy for Angola, which settles the termination of the cooperation programme in Angola and some planning documents developed during 2004. (For consulted references, please refer to *Appendix 2.)*

The main source of information and basis for analysis is the series of interviews with Angolan decision-makers at the Provincial Directorate of Health of Luanda *(Direcção Provincial de Saúde de Luanda, DPSL)*, including the former Coordinators of the three main projects. The Vice Minister for Health was equally interviewed on two occasions. In addition to these centrally placed decision-makers, we were able to meet with some directors of Hospitals and Health Centres and a large number of health workers and to conduct a set of semi-structured or more improvised interviews, depending on their work situation. (Visits were not announced beforehand.) There was also opportunity for some improvised talks with patients at Health Centres and Hospitals.

Representatives of UNICEF and the European Commission were equally interviewed. Some Sida staff was interviewed in Stockholm and Luanda during the first phase of the evaluation. Key persons in Luanda were interviewed on all three occasions. A list of interviewed persons is found in *Appendix 3*.

The team has made considerable efforts to collect general health statistics and specifically relevant data for the MCH sub-sector. The ToR suggest the use of surveys as a method of collecting information, and we admit that this would have been very useful to analyse the quality of services and how the beneficiaries have been affected by the phasing-out of the support. But since surveying is a time consuming method we refrained from even trying, and relied mainly on interviews and critical reading of available documentation, since especially statistics can be of doubtful quality.

In April 2006, some representative Health Centres and Hospitals were identified with the intention of a follow-up during all three field visits. The Health Centres have all been part of the Sida funded MCH projects, and the Hospitals have benefited from the Swedish support through equipment, training of doctors, nurses and midwives, etc. The health units have been visited once, twice or three times, to

[4] Two brief reports have been delivered to Sida's Division of Health after the team's field visits in April and November 2006.

compare the development during the one-year period of the evaluation. Visits were not announced beforehand. The following health units were visited:

- Ana Paula Health Centre in Viana district (visited in April and November 2006 and April 2007);
- Ilha de Luanda Health Centre in Ingombota district (visited in April and November 2006 and April 2007);
- Hoji ya Henda Health Centre in Kazenga district (only visited in November 2006);
- Asa Branca/Kazenga Popular Health Centre in Kazenga district (only visited in November 2006);
- Terra Nova Health Centre in Rangel (only visited in April 2007);
- Cajueiros District[5] Hospital in Kazenga (visited in April and November 2006 and April 2007);
- Kilamba Kiaxi District Hospital in Kilamba Kiaxi district (visited in April 2006 and 2007)
- Luanda General Hospital (Camama) in Kilamba Kiaxi district (only visited in November 2006)
- Augusto N'Gangula Hospital (maternity hospital with paediatric ward; visited in April and November 2006 and April 2007) in Ingombota district;
- Lucrécia Paím Hospital (maternity hospital, visited in April, June[6] and November 2006 and April 2007) in Ingombota district;
- Paediatric Hospital David Bernardino in Ingombota district (visited in June 2006 and April 2007).

During the time spent in Luanda, the team tried to stay in contact with the DPSL staff, to inform about findings, check information and get feedback whenever possible.

## 3.3 Limitations

One serious limitation has been the limited time set aside for this evaluation. The idea of a three-step evaluation extended during one year is certainly interesting, but such a method needs more time than the team had at its disposal. We finalized the evaluation with a certain feeling of frustration, especially since relations and discussions in Luanda tended to become more open-hearted towards the end when we were obliged to finish our work.

The aim of returning to the same Health Units three times to study the development over time was unfortunately not achieved. The comparison is, consequently, not as systematic as expected. Travelling in Luanda is today more time-consuming than ever, irrespective of the day of the week or the hour of the day. Even with a very experienced driver, familiar with all Health Units involved, the team had to spend an absurd number of hours in traffic jams in the city and queues along the suburban roads. In April 2007, rains had made many of the roads impassable. These practical obstacles made it impossible to carry out the field programme to the extent planned and the team failed to repeat the visits to the same units.

All levels of the MCH system are included in this study, i.e. primary level Health Centres with antenatal care[7], delivery room[8] and paediatric emergency ward, the secondary level district Hospitals with delivery ward, operating theatre and paediatric emergency ward, and, finally, the third level with specialized maternity and paediatric Hospitals.

[5] The term *district* is here used for the Portuguese term *município*. Each *município* is composed of several *comunas*.
[6] Some Health Units were visited in June 2006, during the evaluation of the Swedish support 1977–2006.
[7] The period of pregnancy from conception to the onset of labour.
[8] A delivery room *(sala de parto)* is a small delivery ward located at a suburban Health Centre. Nurses and midwives at a delivery room are supposed to only handle normal deliveries and do not perform surgery.

Besides the health institutions, the Sida funded programme has included a course for training of nurses to become specialized midwives. The team could only visit CEP in April and July 2006[9] to observe the ongoing activities and interview the coordinator and teachers. A final brief interview with the coordinator took place in the MoH in April 2007.

In November no semi-annual reports were available from Hospitals or Health Centres. In July 2007, the team got access to a relatively complete draft of DPSL's annual statistical report 2006, which has been quite helpful for our analysis. It was not possible to obtain disaggregated data from each Health Centre and Hospital as expected which makes it difficult to analyse the performance of different Health Units and how possible local problems are reflected in service delivery to different categories of patients.

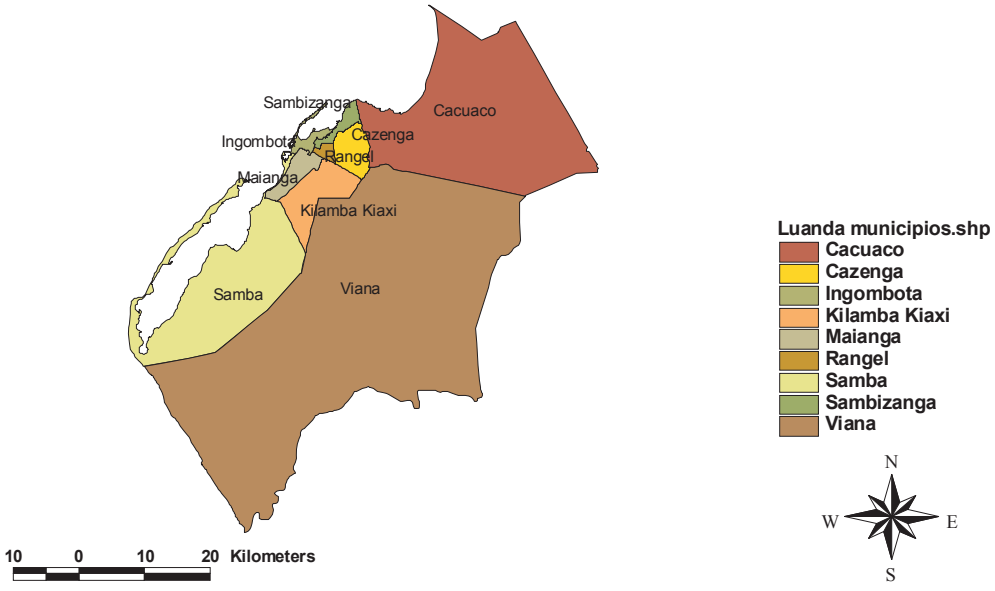
The lack of information from beneficiaries is a serious limitation when assessing a programme like this. Very little information of this kind is available, since most reporting and planning documentation uses an expert perspective where the beneficiaries are absent. We have only found one recent research publication published by Dr. Vita Vemba and his colleague Dr. Isilda Neves, at DPSL, about socio-economic and cultural barriers to utilization of obstetric services in some districts in Luanda. In this little book voices of pregnant women, traditional midwives and other health workers in the communities can be heard.

Due to the short time set aside for assignment with both ambitious and complex ToR, the team does not pretend to give a scientific presentation of the MCH situation before and after phasing-out of the Swedish support. We can only do our best, considering the circumstances, combining interviews, observation and a set of cold figures.

## 3.4 Lack of Demographic Data

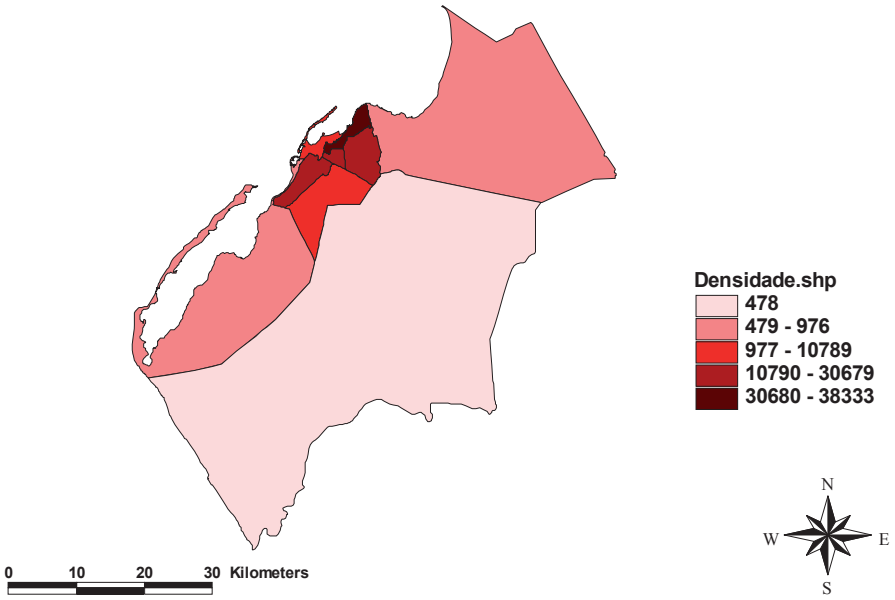
One of the problematic issues when dealing with the health services in Luanda is the lack of demographic data for the province. The province has received huge numbers of refugees during the civil war, and the migration to Luanda has far from stopped since peace was established in 2002. No real population census has been realized since colonial times, and the figures that are used for planning purposes etc., are based on estimates from the National Institute of Statistics *(Instituto Nacional de Estatística/INE)*.

**Figure 1. Luanda Province with its nine districts.**




[9] Another visit to CEP took place in July 2006, as part of the evaluation of Swedish support 1977–2006.

**Figure 2. Population density of the districts in Luanda Province. The most densely populated district is Sambizanga, followed by Kazenga, Kilamba Kiaxi and Maianga.**




*Source figures 1 and 2:* DPSL, 2007.

In this report we will use the estimate which appears in DPSL's annual statistical report for 2006, i.e. 5,391,394 inhabitants, which is based on the estimated natural population growth. Yet, we want to underline that most statistical data presented in this report, are not fully reliable. Statistics from Health Centres and Hospitals are often not complete and sometimes confusing, since few health workers have enough training to produce even rather simple statistics. Data in this report are mainly used to illustrate tendencies, and need be taken with a grain of salt.

Due to the lack of demographic date it is not possible to define the coverage of the public Health Units, which in a way makes our analysis rather uncertain. But by combining estimates in reports produced in Luanda with interview material from the administration and from active health workers we feel confident that we have a grasp of the development since the phasing-out of the Swedish support.

A special point worth being noted is that this evaluation only includes the public Health Units, that is to say, those that come under the DPSL/the Province government.

# 4. Programme Components

## 4.1 Reproductive Health

Mainly against the background of the extremely high institutional (or intrahospital) maternal mortality ratio[10] (MMRi) in Angola, Sida introduced its support to maternal health in the fourth specific agreement (1989–1992) on support to the health sector in Angola. From the beginning the programme was limited to Luanda, although Sida funds at the time went to several national programmes managed by

[10] According to WHO "The most commonly used measure is the maternal mortality ratio, that is the number of maternal deaths during a given time period per 100,000 live births during the same time period. This is a measure of the risk of death once a woman has become pregnant."

the MoH. Above all, it was the dramatically high maternal mortality at the largest, and in theory, most specialized national maternity Lucrécia Paím Hospital that served as an eye-opener to Sida and motivated maternal health as a new programme component.

Initially, the support was directed to the coordination body CAOL *(Coordenação de Atendimento Obstétrico em Luanda/*Coordination of Obstetric Treatment in Luanda) which was created in 1990 within the (then) Provincial Health Delegation of Luanda. CAOL was led by the most competent obstetricians and other leading health staff, and various important stakeholders, such as the women's organization OMA *(Organização da Mulher Angolana)*, UNICEF, and several NGOs were on the committee.

CAOL was, by definition, a coordination mechanism for the Luanda province with the aim of clarifying the roles of the health units (and levels) in the reproductive health system and, gradually, reforming the centralized and ill functioning system. CAOL had the important task to develop methods for improved management of the maternal health care in the province. More specifically, the objective was to improve the level of medical, administrative and technical competence among Angolan health personnel. Apart from coordination, meetings, seminars, and transfer of information, CAOL's role was to channel both Angolan and Swedish funds to different activities and institutions within the maternal health system in the province, but not to be actively involved in providing maternal health services.

The basic reform was the building and equipping of delivery rooms at Health Centres *(Centros de Saúde)* in the nine districts of the province. The idea was to create small maternities located in the suburban areas where the majority of the population live, and through such a measure make it possible to increase the number of institutional deliveries under safe conditions. It goes without saying that practically all deliveries at the time took place at home, with or without the help of a traditional midwife, female relative or neighbour or without any assistance at all. With the improved system, pregnant women should have relatively easier access to antenatal care and high risk pregnancies, and deliveries, should be detected and referred from the Health Centres to the better equipped hospitals at district level (Cajueiros and Kilamba Kiaxi) or, as a last resort, to the specialized maternity hospitals Lucrécia Paím and Augusto N'Gangula in Luanda city. The expected results were not only to bring maternal mortality down through encouraging pregnant women to use the services of the local maternity and, if needed, have complicated deliveries referred, but also to unburden the maternity hospitals which were extremely crowded and, because of historical routine and lack of other services, mainly occupied by normal deliveries. At the time, neither Lucrécia Paím nor Augusto N'Gangula were able to cope with the situation and uphold necessary standards, let alone work methodically to combat the extreme numbers of maternal deaths.

With the time, maternal health became reproductive health, thus including family planning services for adults and separate family planning services for youth, and during recent years counselling and treatment of HIV infected pregnant women and their new-born children.

In 1995, Sida had the MCH programme in Luanda outsourced to the consultancy company InDevelop, and CAOL, as well as the other components of the programme, gradually developed into projects outside of the DPSL sphere. The Sida supported health units, which seem to have defined themselves as "belonging" to CAOL rather than to DPSL, worked under relatively privileged conditions compared to others not included in the Sida programme.

The technical assistance mainly focused on training of staff, development of better norms, etc. to improve the quality of all aspects of the reproductive health services. Importation of all kinds of equipment, dressing materials and drugs, etc. was equally mainly handled by the project. A long-term public health specialist from Brazil has been supporting the project during the phasing-out period. Through the years, CAOL has received the lion's share of the resources, financial as well as in the form of technical assistance.

## 4.2 Children's Health

CAPEL *(Coordenação de Atendimento Pediátrico de Luanda*/Coordination of Paediatric Treatment in Luanda) was created in the mid-1990's as a coordinating body for the child health sub-sector in the Luanda province, inspired by the CAOL model, since the problems were partly the same as for maternal health. There was a need to decentralize paediatric services through creating emergency wards in the suburban districts and to improve the quality of child health services in general. The building up of a functioning referral system was also an important objective, to help unburden the national Paediatric Hospital David Bernardino in the city, since the pattern was similar to the situation in the big maternity hospitals. The Paediatric Hospital was receiving hundreds of children per day with symptoms that did not need specialized care, but parents had simply nowhere else to go with their sick children since paediatric services were practically non-existent in the city and in the suburbs, except for immunization.

The objectives of the child health project were to combat infant and child mortality, to improve child health in general and, logically, to improve and strengthen the child health care. The paediatric units were established at suburban Health Centres (which also have delivery rooms) so that parents can reach medical services closer to home. The national Paediatric Hospital in Luanda has, equally, got financial support and technical assistance. (In 2006, a new paediatric clinic was inaugurated at Augusto N'Gangula maternity hospital. This ward was financed by the Angolan government.)

Support to immunization has been channelled through UNICEF to the Extended Programme of Immunization (EPI) since the first specific agreement signed in 1979, with the aim of reducing illness and death in preventable diseases, such as measles, TB, diphtheria, tetanus (including pregnant women), whooping-cough, etc.

Also CAPEL got both financial support and technical assistance – but far less than CAOL, though – to implement training of staff, and to make general improvements of services at all levels. CAPEL had, equally, a long-term public health specialist from Brazil to support the project during the phasing-out period.

## 4.3 Training of Midwives

The Course for Specialization of Midwives (CEP) started in 1998, and received Sida support from the beginning in the form of funding and technical assistance. CEP has four full-time teachers (2006–2007) and can also use specialist teachers from the maternity hospitals and the Faculty of Medicine at *Universidade Agostinho Neto* (Agostinho Neto University).

Students have been recruited from Luanda and other provinces. The fourth course was concluded in the end of April 2006. During the phasing-out period, work started with the establishing of two new midwifery schools in Malanje and Huíla provinces, to expand this training facility to other regions where there is an urgent need for trained midwives.

From the beginning of 2004, the school has been totally funded by the Human Resources Department of the Ministry of Health. The midwifery school has not had any technical assistance during the phasing-out period.

## 4.4 Institutional Support

The Institutional Support Project *(Projecto de Apoio Institucional*/PAI) started with the phasing-out of the programme. It was based at DPSL, the Provincial Directorate of Health of Luanda, and was mainly a channel for major investments during the phasing-out period.

The project aimed at expanding and strengthening the health system in the Luanda province, and,

simultaneously, integrating the different projects within DPSL through defining their field of activities. The implementation of the strategy for Improvement of Quality in Primary Health Care is another key element, which has been supported by the project. Within the framework of the Swedish support, eight areas of intervention were defined:

- Work with the communities
- Laboratories
- Blood bank
- Bio-security
- HIV/AIDS/STD
- Referral system
- Planning and management
- Training

The HIV/AIDS/STD and blood bank components ware later excluded from the project, since DPSL expected to get other funding, e.g. EU for the blood bank project[11].

# 5. The Phasing out of the Programme

## 5.1 Background and Agreements

In 2003 the Swedish government and Sida decided to terminate the support to MCH in Luanda. This decision was based on the analysis made by Sida's Africa department *(Min. of Foreign Affairs, Country strategy, 2003)*. In its analysis, the Swedish government underlined the great insecurity regarding Angola's development policy, the lack of transparency of the state financial situation and the fact that Angola still had not reached any agreement with the so called Bretton Woods institutions (the World Bank, WTO and IMF) concluding that it was no longer motivated to continue a long-term bilateral development cooperation programme in the health sector. In addition, the country's rich natural resources (mainly oil) could be used for reconstruction and social development after the end of the civil war in 2002. Swedish cooperation should thus be phased out. The Country Strategy finally stated that:

> The conditions for future bilateral long-term development cooperation shall depend on the development policy of Angola's government and its financial needs. Only if necessary conditions are met, long-term development cooperation can come into question. Among the important issues that the government of Angola needs to solve are economic reforms, increased democratization, general presidential and parliamentary elections and an agreement with the IMF. If steps should be taken, Sida can present a proposal regarding a renewed analysis during the Country Strategy period of whether there exist development policy conditions for bilateral development cooperation with Sweden *(Min. of Foreign Affairs, Country Strategy, 2003, p.19)*.

[11] Sida is funding an HIV/AIDS programme through UNFPA since 2006, but the blood bank has so far up to 2007 not been created.

The final version of the Country Strategy and the decision to end the cooperation between Sweden and Angola was like a bolt from out of the blue. Sida's Health Division had been preparing since 2002 a continuation of the support based on a three-year specific agreement and had also commissioned an evaluation of the programme to give an input for planning of the new phase from 2004. The evaluation team got the news about the phasing-out of the programme upon leaving for the field trip to Angola, but fulfilled their task with unaltered ToR.

The specific agreement regarding support to the Health sector was terminating 31 December, 2003, and a final agreement for the phasing-out period was elaborated and planned to take effect 1 January, 2004.

## 5.2 Delays 2004 and 2005

Due to the audit of the MCH programme, including CEP, performed by Ernst & Young in Luanda 21 October–2 November 2003, Sida decided to postpone the signing of the agreement for the period 2004–2005 and withhold the disbursement of funds to the ongoing programme. The effect was an almost standstill of the whole programme, except for CEP which was able to continue its course with funds from the Department of Human Resources of the MoH.

After responses and clarifications from the Angolan institutions, an agreement was finally signed on 31 May, 2004.

As a consequence, the phasing-out period only started formally on 1 June, 2004 and was supposed to terminate 31 December, 2005. The contract with the implementation consultant InDevelop was signed without a new tender procedure for the same period (8 June, 2004–31 December, 2005).

In the beginning of 2005, Angola had an outbreak of Marburg fever which caused another delay of the implementation of the programme. All health staff had to be mobilized to combat the Marburg epidemic, and the MoH/DPSL asked Sida for an extension of the programme and its funding for six months. Sida agreed to prolong the agreement with another three months, i.e. until March 31, 2006.

## 5.3 Scope and Objectives of the Agreement

The main objective of DPSL's Health project 2004–2005, MINSA-Sida, was

> … to contribute to a better health for the mothers and children who live in Luanda province. The specific objectives are:
>
> – Improve the quality of the existing services
>
> – Expand the basic health services to make them available to the whole population (of Luanda)
>
> – Improve the knowledge and competence of the health staff
>
> – Improve the integration[12] of programmes and services
>
> – Strengthen the planning and management capacity at the Provincial Directorate of Health, at the health sections of the districts, and at the peripheral health units, thus assuring the sustainability of the health activities *(DPSL, Projecto de Saúde 2004–2005, MINSA-Asdi)*.

[12] In this report we interpret integration as a process strengthening the needed close connections between the levels of the health system from PHC level to the most specialized hospital level, but also integration of the projects CAOL and CAPEL into DPSL and in the case of CEP into the MoH.

The agreement specifically states Angola's obligations saying, among other things, that:

> … since this will be the last agreement, Angola should suggest and give alternatives to the [present] funding of the programme from 2006, to assure its sustainability. Especial emphasis should be given to funding alternatives for those services at Reproductive and Child Health Units that depend on the Provincial Directorate of Health of Luanda. Since it is foreseen to make several investments during this last agreement, maintenance of these investments must be assured through [the budget for] recurrent expenses *(Swedish Embassy/MoH, Specific agreement, 2004)*.

# 6. Issues to be Analysed

## 6.1 Goals for the Phasing-out Period

The Swedish goal for the phasing-out period was to help achieving sustainability of all the programme components by strategic planning of the phasing-out period and by ensuring Angolan autonomy through training of staff at different levels and boosting of certain resources.

The Angolan goal was to achieve sustainability of the programme components by strategic planning of the phasing-out period and also by preparing for the best use of scarce resources in the future, e.g. through better logistic services and maintenance of vehicles and equipment.

The connecting thought of the evaluation is, naturally, if and how this mutual goal of achieving sustainability during the phasing-out period was met. These issues will be analysed together with other aspects of the development from the moment Sida and its consultant InDevelop have retired from the health sector in Luanda.

## 6.2 Activities 2004–2006

At the first visit in April 2006, the team could verify that the day-to-day activities of all the projects had been going on at normal pace during the phasing-out period, with the exception of the first five months of 2004 and three months in the beginning of 2005 (see above). With the exception of CAPEL and CEP, final reports had been delivered to the Swedish Embassy.

The phasing-out activities, in the form of special training of staff from the reproductive and child health projects, courses/workshops in logistics and maintenance of vehicles, etc. had been implemented according to plans. The administrative manual used by the projects was thoroughly revised by the InDevelop administrator with the aim of straightening the financial and general administrative routines and thus minimize risks of errors or mismanagement in the future. Several training activities were organized for project staff to facilitate the implementation of the norms and recommendations in the manual. Extra purchases of drugs and some complementary equipment were also made during this period within the framework of institutional support. Five new ambulances were, for example, ordered but not yet delivered (in 2006).

## 6.3 Effects on Service Delivery and Beneficiaries

The issue of how the phasing-out has affected the beneficiaries and the service delivery is a main problem that needs a more profound analysis to produce information that is meaningful – and helpful – to both parties (see 3.3). The information collected through report reading, other relevant data obtained through interviews and, further, checking on available drugs and other supplies and observing the status of existing equipment has given a certain basis for analysing these aspects.

Information on so called *gasosas*[13] was collected randomly to know how much staff presently charge for antenatal care and delivery or for immunization, consultation and drugs for sick children. *Gasosas,* or "anarchic fees" which is the official term, are illegal charges because reproductive and child health care is free in Angola according to law.

Although this is a phenomenon that seems to have nothing to do with the phasing-out of the Swedish support, it is not without interest. The charging of *gasosas* has varied over time depending on the evolution of salary levels, regular payment of salaries, etc. which can have been affected by the phasing-out of the support. The salary/*gasosa* problem has definitely a bearing on the beneficiaries, since pricing is considered one of the most important barriers that prevent women/families from seeking care during pregnancy, at delivery and for their sick children.

### 6.4 Effects on Future Sustainability

The main issue for the future – and of this study – is the possible sustainability of the reproductive and child health care in the Luanda province and the development of CEP (including the new courses in Huíla and Malanje). How has the phasing-out affected the different institutions involved in the programme? Have the reproductive and child health projects become fully integrated into the health system of the Luanda province?

Should the phasing-out have been announced and prepared more in advance? What could have been done better – on the Swedish side as well as on the Angolan side?

### 6.5 Recommendations for the Future

According to the ToR, the evaluation shall formulate recommendations for the Angolan as well as the Swedish side that can be relevant for similar processes in the future. Besides such recommendations, we have also drawn up some concrete advice directed at DPSL, mainly based on our observations and interviews with staff at Health Centres and Hospitals.

## 7. Indicators for Follow-up 2006–2007

At the first visit in Luanda the team developed a baseline for the evaluation through isolating some key issues to be analysed and defined a number of tentative indicators that seemed relevant for follow-up of the development during the first year without Sida funding and the technical assistance from InDevelop. The intention was to measure success, setbacks and sustainability of the MCH institutions in Luanda with the help of these indicators, e.g. the number of institutional deliveries, intrahospital maternal mortality, anti-tetanus immunization of pregnant women, perinatal mortality, <1 year and <5 year mortality, etc.

The indicators were listed without any real overview of available statistics and their quality, and we have actually found that the set of indicators was far too ambitious. We soon found out that there are not enough data available to study positive or negative developments. We have, however, used the indicators as a checklist and tried to steer interviews and data collection to create a picture of the evolution and the situation we could observe until our final field visit in April 2007.

[13] The Portuguese term *gasosa* means "soft drink" and stands for the money that patients have to pay health staff under the table to be attended (or doormen simply to be let in) at Health Centres or Hospitals.

**General indicators – evolution 2006–2007**

1. Number of staff at DPSL working with MCH April 2006, November 2006 and April 2007
2. What staff categories have left the sub-sector Nov. 2006 and April 2007? (Midwifes, nurses, obstetricians; nurses, paediatricians; male or female staff).
3. Trend of wages among DPSL MCH staff 2006–2007 in relation to inflation and real purchasing power.
4. Percentage of the OGE (state budget) allocated to the health sector: national level, Luanda province and specifically to MCH sub-sector 2006 and 2007. Per capita investment in health sector.
5. Budget, staff and other resources for the midwifery course in Luanda.
6. Equipment April 2006, November 2006 and April 2007: ambulances – are they in place, are they working? Stock of clothes and other textiles for operating-room staff. Blood pressure cuffs. (All levels that have received support – reproductive health and child health.)[14]
7. Cards: Antenatal care, partogram, immunization card.
8. Drugs: Oxytocin, magnesium sulfate, diazepam, terbutalol, drip solution, oral rehydration solution, antibiotics, anti-malarial drugs.
9. Referral system: 3rd level – Health centres – delivery room, paediatric emergency ward; 2nd level – referral Hospital (Kilamba Kiaxi and Cajueiros); 1st level – Lucrécia Paím Hospital, Augusto N'Gangula Hospital and Paediatric Hospital David Bernardino in Luanda.
10. Development during 2006 and 2007, increased number of normal deliveries and normal child health calls at 3rd and 2nd level or not?

**Reproductive and child health indicators**

*Coverage – evolution 2006–2007*

1. Number of deliveries at Health Centres (Salas de parto).
2. Number of antenatal care visits at Health Centres.
3. Number of antenatal care visits in relation to deliveries at Health Centres.
4. Maternal mortality ratio, case fatality rate.
5. Tetanus immunization of pregnant women.
6. Patient fees at different levels/for different services.

*Family planning/STD – evolution 2006–2007*

1. Number of FP visits at Health Centres.
2. Number of IUDs.
3. Number of condoms distributed.
4. Number of Health Centres with Youth Counselling services. (If possible gender disaggregated information).
5. Number of visits at Youth Counselling services.

*Child health – evolution 2006–2007*

1. <1 year mortality ratio.
2. Perinatal mortality ratio, incl. intrauterine foetus mortality (up to 7 days post partum).
3. <5 year mortality ratio.
4. Immunization: BCG, DTP, measles, etc.

[14] According to the director of DPSL, Dr. Vita Vemba, there is still no inventory (April 2006).

# 8. Functioning of the MCH Sub-sector

## 8.1 Budget for the Health Sector

*Government expenditure*

The total whole government budget 2007 is USD 31.1 billion. The health sector still receives a meagre percentage of the government budget in relation to the crying needs of the people. However, the state budget as a whole has increased substantially during the last few years. This means that the evolution of the resources set aside for the health sector in spite of all is positive. The Ministry of Finance (MoF) anticipates an inflation of 10 per cent and a GNI growth of 31.2 per cent for 2007.

**Table 1. Development of GNI, government budget and health sector budget 2001–2207. Million USD.**

| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006* | 2007* |
|---|---|---|---|---|---|---|---|
| Nominal GNI | 9,474 | 11,386 | 13,956 | 19,800 | 32,810 | 40,086 | 58,117 |
| Total government expenditure | 4,386 | 5,401 | 6,141 | 7,095 | 10,159 | 23,110 | 31,104 |
| Health sector expenditure | 263,6 | 213,5 | 298,6 | 313,8 | 447,2 | 1.020,9 | 1.144,7 |
| Health – % of government expenditure | 6.01 | 3.95 | 4.86 | 4.42 | 4.40 | 4.42 | 3.68 |

* Figures for 2006 and 2007 are estimated expenditures and not expenditures incurred. The GNI figures 2001–2005 come from IMF, while for the two last years the figures come from the Government's projections.

*Source:* Cassoma & Vinyals ed., 2007

Considering the health indicators in Angola compared to those of the other countries in the region, it is evident that Angola will need to increase the resources set aside for the health sector. Compared to some of the SADC countries,[15] Angola has the lowest percentage of government expenditure for the health sector – 4.9 per cent in 2003 – but the worst indicators of child mortality (260/1000 in 2004) and maternal mortality (1,700/100,000 live births in 2000), according to the study *Despesa Pública no Sector da Saúde 2000–2007/Public Expenditure in the Health Sector 2000–2007* by Cassoma & Vinyals *(Cassoma & Vinyals, 2007)*. The health sector has, however, for a long time benefited most from donor contributions, with 16 per cent of the total aid in 2005. The European Union and the EU countries are the major donors with 22.07 per cent of the donor contributions to the sector for the same year. An interesting detail is that 48 per cent of the aid contributions are directed towards health institutions at the national level, such as national specialized hospitals and institutes.

*Province government health expenditure*

Since Luanda is the most densely populated province of the country, with approximately one third of the population, it is goes without saying that the province and the capital receive the major part of the health sector budget. (The specialized health institutions with national coverage are located in Luanda, but are not part of the province government budget intended for the health sector.)

According to Cassoma & Vinyals (idem), the health expenditure in Luanda for the period 2000–2005 has developed in the following way (million USD):

Year 2000: 52.07 Year 2003: 34.26

Year 2001: 28.2 Year 2004: 34.5

Year 2002: 26.6 Year 2005: 52.06

[15] Angola, Botswana, Mozambique, Namibia, South Africa, Zambia and Zimbabwe.

There is no figure for 2006, but according to information from DPSL regarding the approved budget, the budget for 2007 has more than doubled since 2005 and amounts to approximately USD 115 million. This amount does not include salaries and other expenditures with staff, since salaries are transferred from the MoF/MINSA.

Although resources are far from sufficient, this budget boost gives possibilities for further development of the MCH services and to initiate other important reforms to benefit the millions of people in Luanda who seek health care from the public Health Units.

The health expenditure *per capita* gives relatively unimportant information regarding the functioning and coverage of the health system. In Luanda, the average *per capita* expenditure 2003–2005 amounted to USD 10.5, while for example the sparsely-populated Namibe province had a spending of USD 35 *per capita* for the same period. This can be explained by the system used by the MoF through which the same budget resources – in 2005 USD 20 million – was distributed to all provinces alike without any specific criteria based on population, needs, combat of endemic diseases or HIV, etc.

## 8.2 Human Resources of the MCH Sub-sector

It has not been possible to get specified information from the Department of Human Resources at DPSL to compare the staff situation and possible changes from the beginning of the phasing-out period 2004 up to 2007.

*Staffing situation*

From the many interviews we have deduced that there is no strong tendency of staff leaving the health units, or the DPSL central services since the Swedish funding stopped. However, the MCH programme has lost staff. Over the years, CAOL had recruited some specialized nurses and midwives to serve as supervisors and trainers during the project period, and 4–5 of them have returned to their original workplace Lucrécia Paím Hospital after the project was finished. In April 2007 the MCH programme had only eight midwives/supervisors. Yet, they have not left the public health sector or the MCH sub-sector, which is certainly a positive finding. According to the information from DPSL, some Health Centres have recruited new staff for the paediatric wards as well as for delivery rooms. A critical observation from the same source is that health staff with specialized training, e.g. in paediatrics, are moved internally to any other area so that their special competence can no longer be utilized.

Training continues to strengthen the paediatric services and CEP is slowly contributing to the increase in the number of specialized midwives. At Health Centres several male and female nurses mentioned their own personal interest to study to be doctors or midwives.

On the other hand, several informants stated that nurses and midwives more and more tend to start working part-time at private clinics, but without leaving their position in the public sector. This model has been applied by doctors for decades, with very negative effects for the (public) hospitals. We doubt it that the "private clinic model" has anything to do with the phasing-out of the Swedish support; it is fully in line with the development in Angola, where the private sector is expanding in general terms and the law opens for private medicine, pharmacies, etc., for the past fifteen years. And as long as public sector employed health staff continue to earn very low salaries it will be difficult to retain qualified staff, especially in Luanda where there is an immense market for all kinds of health services.

The present (April 2007) staffing situation at Health Centres in the Luanda province is the following *(DPSL, 2007):*

Number of doctors: 23
Number of nurses (male and female): 1,045
(No data for Centres in Rangel and Viana districts.)

The hospitals with delivery wards have the following situation:

Cajueiros Hospital, number of doctors: 35
Kilamba Kiaxi Hospital, number of doctors: 17
Augusto N'Gangula Hospital, number of doctors: 46

Cajueiros Hospital, number of nurses (male and female): 337
Kilamba Kiaxi Hospital, number of nurses (male and female): 355
Augusto N'Gangula Hospital, number of nurses (male and female): 401

Among the Health Centres that have three doctors employed (maximum), two are situated in the city centre. Yet, the most densely populated district, Sambizanga, is part of Luanda city but has only four doctors in all, and two of its four Health Centres have no doctor. In Kazenga district, which according to estimates has around 1.5 million inhabitants, there are a total number of ten doctors at the ten Health Centres and five Centres are without a doctor. The biggest Centre in Kazenga has three doctors and 95 nurses, which gives an idea of scale and pressure on suburban Health Centres.

It should be noted that all Health Centres receive all kind of patients and among them pregnant women and sick children. As far as we have found, none of the Centres has an obstetrician or a specialized paediatrician, while nurses can be specialized through training courses or workshops organized by CAOL or CAPEL or supporting NGOs, etc. Among the Health Units that come under the provincial health administration only Augusto N'Gangula is a maternity hospital which also ha a paediatric ward inaugurated in 2006. Presently, there are only 51 Angolan obstetricians in the whole country. They are concentrated in Luanda (as the majority of the physicians) and many of them dedicate most of their time to private clinics.

With the few doctors employed at Health Centres, one can conclude that nurses with medium or basic level diploma – *técnicos médios or básicos* – shoulder the burden of the health services, together with medical laboratory technicians, administrative staff, and hundreds of cleaners, laundry workers, drivers and other workers.

*Salaries*

The salary situation is a crucial and multifaceted problem affecting the whole health sector. Firstly, salaries for most staff categories are too low compared to many health workers qualifications, years of service and responsibility. Secondly, the cost of living especially in Luanda has permanently been running away and it is often said that Luanda today has beaten Tokyo, which used to have world record sky-high cost of living. Thirdly, salaries are not paid in due time and staff at Health Centre continue telling that payment of salaries is lagging behind since several months.

The low and irregularly paid salaries was the reason behind the incentive scheme introduced by CAOL/Sida in the beginning of the 1990's to make mainly midwives, but eventually also other staff categories, to appear regularly at the workplace so that the newly established delivery rooms at the peripheral/suburban Health Centres should function properly. Incentives were abolished gradually in the beginning of the 2000s and have, thus, not existed during the phasing-out period.

The salary system has step by step started functioning, although salaries are still very low. There is a proposal of a thorough reform of the system for the whole Health Sector, but it is not yet implemented. But salaries have, for a start, been decentralized to the provincial level and payment seems slowly to improve. According to the Department of Human Resources of DPSL there has been a salary increase every third month during 2006, and further salary adjustments are foreseen during 2007.

According to DPSL's basic salary schedule for 2007, doctors earn a monthly salary of USD 957, while nurses[16] earn USD 239, medical technicians USD 398 and administrative staff USD 177. Hospital directors and clinic superintendents have the same salary as doctors, while the directors of the health section of the district administration have a slightly lower salary, USD 886. In reality, different categories receive different subsidies, according to responsibility and performance, which means that a clinic superintendent can earn up to around USD 2,000 (compared to USD 25 in 1999!) and salaries for nurses have increased from USD 4 in 1999 to USD 1,404 in 2005 *(MINSA/DNRH, 2005)*.

## 8.3 Infrastructure

*Lucrécia Paím and Augusto N'Gangula Hospitals*

The biggest and most specialized maternity, Lucrécia Paím Hospital, was still under rebuilding in April 2007, but has mainly been functioning during the building time. The new parts of the hospital have sophisticated equipment, new beds and other furniture and lots of space for the patients. (In spite of this one could in November see three women sharing one bed in the new post partum ward while some women were even lying on the floor with their babies.) It was not explained whether some wards will be for paying patients and the others for ordinary patients.

The neonatal ward was not ready, but a number of incubators were lined up in the corridor waiting to be installed. The rebuilding of the eclampsia ward was still not ready, and was simply closed.

The paediatric section and neonatal ward of Augusto N'Gangula Hospital was inaugurated in the beginning of 2006. This part of the hospital is well equipped, with four incubators, oxygen supply, etc., but is, strangely enough, lacking heating mattresses for the babies.

The hospital has a well-filled reference library and a computer room of high standard.

Needless to say, both hospitals[17] have running water and electricity plus generators.

*Cajueiros and Kilamba Kiaxi Hospitals*

These are, naturally, better equipped than Health Centres, and have water/sewage disposal and electricity.

In spite of the better standard at the hospitals, they suffer from the insufficiencies of the power supply. At the Kilamba Kiaxi maternity some deliveries during the night have to take place by candlelight because of the frequent power cuts. This also creates problems since some of the necessary (and available) equipment only works with electricity, e.g. incubators, vacuum extractors and heating lamps.

*Health Centres*

It goes without saying that the situation at the Health Centres is quite different. Two of the visited Centres are big – Hoji ya Henda with 129 employees and Asa Branca with 121 – and serve a very populated area. Ana Paula in Viana and Ilha in central Luanda are both smaller Centres.

In terms of general infrastructure, many of the Health Centres are extremely poor, including those that had Swedish support through CAOL and CAPEL. Many Centres lack running water and generators, and if they have a generator it is often not working because of lacking maintenance/repair or because there is no budget for buying diesel. (Only from 2007 Health Centres have a decentralized budget for running costs distributed by the District Health Sections.)

[16] Salaries for nurses are not differentiated according to academic level, i.e. basic or middle level course. The salary schedule also does not consider years of service, etc., only basic salaries.

[17] The Camama Hospital is not included in the evaluation, since it was inaugurated after the phasing-out of the Sida programme.

## 8.4 Logistics

*Ambulances*

Regarding the logistic situation, Hospitals and Centres "in principle" have ambulances, but only very few of them are working. Cajueiros Hospital has, for example, three ambulances but only three drivers, which makes it very complicated to have the ambulances work full-time. The ambulances imported through the Institutional Support Project are fortunately functioning (with one exception, April 2007) and of four older vans that belonged to DPSL three have been converted into ambulances, as planned, and distributed to the Hospitals.

Because of the shortage of ambulances patients who need to be transferred to a second or first level hospital have to use private cars or taxi/minibus (candongueiro) and pay for the transport themselves. The failing transport system and lack of radio communication in combination with the practically permanent traffic congestion in Luanda is a main hindrance to making the referral system function in a safe way. It should be noted, though, that this situation is not new, with the exception of the recent dismantling of the radio communication system.

*Radio communication*

Radio communication between Health Centres and the reference hospitals or ambulance drivers is no longer working. Staff has not been informed about the reason and some say that "CAOL came and collected the Motorola", while others explain that the system stopped functioning because of the building works at Lucrécia Paím since the radio transmitter was located at the roof of the hospital. At the Centres the common view seems to be that radio is the safest means of communication when patients need to be transferred and in other emergency situations. Asa Branca Health Centre reported that the District Health Delegate is trying to re-establish the radio system. In April 2006, though, several people including the Provincial Director, were of the opinion that cell phones were more practical than the old-fashioned radio system. In April 2007, opinions seemed to be vaguer at DPSL, but there is no doubt that health staff in the periphery and such crucial staff as ambulance drivers prefer – and trust – radio before cell phones[18].

## 8.5 Equipment at Health Centres and Hospitals

Since there is no inventory of equipment at health units in Luanda province, this indicator cannot be used for any systematic comparison. The team has, of course, observed and asked questions about all kinds of equipment and supplies. When it comes to equipment the findings are rather discouraging, since a lot of the donated equipment is out of order and cannot be repaired because of lack of funds. That goes for all kinds of equipment, whether bought through the Sida programme or not.

Generators are often breaking down and seldom repaired. Since Health Centres have only one generator and only few hours of electricity distributed via the mains supply, the generator is quickly worn out and cannot be repaired because of lack of funds. In other cases, generators stand idle because of lack of diesel or spare parts.

Vacuum extractors, aspirators, incubators and other equipment needed during delivery and for the new-born are not always functioning. Staff at Health Centres does not know whether donated equipment is of good quality and worth repairing or not, which country of origin, where to find spare parts etc. – the problem is similar to that of vehicles and ambulances.

[18] An observation worth mentioning is that Swedish rescue services and ambulances use communication radio, since it is considered the safest and most practical means of communication.

The fundamental issue regarding vehicles and the more sophisticated equipment is the lack of funds at Health Centres and Hospitals. Until year 2007 Health Centres had no budget at all from the province government, which has contributed to today's severe situation. Hospitals have a budget, but far too limited to keep the institution running at a normal pace.

Other kinds of equipment, such as blood pressure cuffs, stethoscopes, etc. generally exist but are mostly old and not always clean. Staff has usually, though, clean clothes, and protective aprons and plastic sheets exist in the delivery rooms.

In 2006, DPSL placed orders for importation of a the first huge batch of hospital equipment – beds and other furniture and medical equipment of all kinds – for Hospitals and Health Centres in the province. This equipment had started to arrive in April 2007 and was waiting in Luanda harbour to be cleared. This investment means a great improvement which will also benefit the MCH sub-sector, although the main investment is meant to furnish the new Hospital Geral de Luanda in Camama.

Besides the big re-equipment programme (with national funding), DPSL has also since 2006 one mobile modern gynaecological surgery to reach the most remote areas of the province where there are no Health Centres or not even Health Posts.

## 8.6 Maintenance of Vehicles and Equipment

The classical issue is the maintenance of vehicles. One of the district hospitals has a veritable ambulance cemetery in its backyard, and we did not visit any Health Centre or hospital that had not at least one ambulance standing idle – or totally wrecked. One problem – not only in Angola – is the variety of makes of ambulances and other vehicles that are received as donations from multi- or bilateral cooperation agencies or NGOs. This vehicle jungle is impossible to handle and maintain, and the responsibility for this problem should at least be shared between donors and the receiving party who very seldom can say "No, thank you" to a Chinese, Indian, Italian, Korean or whatever ambulance added to the already confused vehicle pool. In 2005, a short time consultant recruited by InDevelop made a general survey of the vehicle fleet, and made a strong recommendation to avoid the disparity of makes and try to create a uniform vehicle fleet. Such a decision has recently been taken (2006) and norms have been launched at province level, to facilitate maintenance.

It goes without saying that maintenance of vehicles is a permanent headache in Luanda, and DPSL has had many setbacks when trying to make contracts with garages, since vehicles were not repaired on time – it took e.g. nine months to have an ambulance repaired, since the garage was lacking capacity. Spare parts are also a problem, especially with the broad variety of makes that exists within DPSL.

Another serious problem is the generators at Hospitals and Health Centres. At Centres where there is only one generator that has to work during long periods of power cuts, and often breaks down but there is no possibility for quick repair.

Eight generators were imported through a Swedish owned firm in 2005 (through PAI), and according to a clause in the contract the firm had the right to earn a commission on the condition to guarantee the maintenance of the equipment through a trustworthy repair shop.

InDevelop took on the responsibility for regular/preventive maintenance and repair of vehicles and equipment, and DPSL staff was left with very limited experience since the phasing-out period was too short to really train staff to take over this heavy burden. Today there is a small maintenance team of three people (one person based at DPSL, one mechanic and one electrician) catering for the whole province. The electrician is especially responsible for repair of generators. The mechanic took a course on preventive maintenance during the phasing-out period. PAI also funded a course in Brazil on maintenance and repair of medical equipment.

The team is supposed to make regular visits to Health Centres and Hospitals to check on vehicles and equipment, but when asked directly none of the interviewed administrators at the Health Centres knew about the existence of such a team. This indicates that the maintenance system is still not organized and fully functioning.

## 8.7 Availability of Cards

The cards used for antenatal consultations, *cartão da grávida,* are mostly used at the Health Centres. In some cases the Centre has run out of cards, and need to make photo copies locally. These cards were earlier always printed by the printing office of the MoH, but DPSL does not seem to place orders at the Ministry's print shop any longer.

One of the visited Centres had also run out of partogram forms, and was equally making their own copies now and then. It was not clear why some Centres do have these essential cards/forms and others not. This can be due to the information gap between the periphery and the centre (the District Health Section or DPSL), since all distribution was handled by CAOL/CAPEL/InDevelop as long as the projects were running.

There seems to be no lack of immunization cards for children, since the Extended Programme of Immunization (EPI) functions as a vertical organization within the health system and immunization cards are thus supplied by UNICEF.

## 8.8 Availability of Essential Drugs

In November 2006, all visited Health Centres were complaining about the irregular supply of essential drugs compared to the situation before the phasing-out of the Sida support. The PHC drug kits had not arrived since six months to one year. The general lack of drugs was later explained by the Essential Drugs Programme (EDP). Importation had been delayed, because IDA had to substitute one of the suppliers and the whole procedure was held up for a long time. The drug import funded by the EU was also stopped because of tender problems, and this combination led to a very troublesome situation not only in Luanda, but all over the country. In April 2007, the team could fortunately observe that the EDP drug kits had arrived to Centres and Hospitals and were only waiting to be unpacked.

In November, some Health Centres were lacking oxytocin, iron tablets, etc., while others still had some remains from the CAOL supply. One paediatric ward was lacking oral rehydration salts, sulfa/antibiotics, and antipyretics, etc. One Health Centre had bought drugs, gloves, syringes, etc., hoping to be refunded by DPSL.

A general observation is that all visited Health Centres had less quantity of drugs in supply in November 2006 (and some drugs were simply lacking) compared to the situation in April. Some Centres had not received any drugs since six months, others since eight months, and so forth. In some cases only the delivery room and the paediatric ward had received drugs, while the Centre as such was still without drugs. The PHC director, Dr. Isilda Neves, however explained that DPSL still had drugs in supply and that the Centres must inform about their needs. It is evident that the Centres have different planning and management capacity, which might explain some of the difficulties to maintain an even level of drugs in supply.

In April 2007, practically all visited Hospitals and Centres had received their share of drugs from EDP, but the delivery was so recent that the unpacking and inventory was still not ready.

## 8.9 Present Resource Situation

*External support*

MCH in the Luanda province has currently quite limited external support. Health Centres and Hospitals benefit from selective contributions/measures from the Global Fund (the malaria programme) or the World Bank funded HIV programme, but these contributions mainly involve drugs. UNICEF has, however, in 2007 launched a decentralized programme of support to the District Committees for the Prevention of Maternal Mortality. The programme supports five Districts in each province, including Luanda with USD 10,000 for each District Health Section. Since the Committees, as well as the programme, are recently established it was not possible to collect any systematic information on their strategies and working methods.

WHO also supports MCH in Luanda and four other provinces with EU funding. The programme includes material and equipment of delivery rooms at Health Centres, on-the-job training, manuals/didactic material, training in IMCI, STDs and reproductive health with the trainers who have been working with CAOL and CAPEL.

USAID is elaborating a project to be implemented by NGOs for support of "Essential Health Services", i.e. primary health care. In the end of April a seminar is planned on the system of referral and counter-referral.

*National resources*

Since 2006, most of the health system in Luanda is financed by national resources. National hospitals, such as Lucrécia Paím and Paediatric Hospital David Bernardino have always received their funds directly from the MoF. Augusto N'Gangula Hospital, which was upgraded to a general hospital in 2006 (although it still comes under the DPSL) and the new Camama, equally receive their funds from the MoF, but disbursements were irregular during 2006 to Augusto N'Gangula.

Cajueiros is today a provincial hospital[19], and equally receives its funds from the MoF. The indicative budget for 2006 was 40 MKz, but it should be noted that in the Angolan budget system an indicative budget amount is not equal to disbursement of the planned amount. Besides this uncertainty, all hospitals received an official letter of 20 October 2006 from the Provincial Director of Health communicating the decision by the Budget Commission of the MoF that 2006 funds were to be cut by 15 per cent. The consequence was that the funds for November and December were frozen in, and that these hospitals had to rely solely on the so- called *comparticipações*[20] for running costs during the rest of the year, i.e. the fees charged for consultations, blood tests, etc. The cost for a consultation at a Health Centre was Kz 200 in 2006 (appr. USD 2.5).

None of the visited Health Centres had any budget for running costs during 2006, and were thus, relying on *comparticipações*. Asa Branca is, for example, a referral centre, but even so it had no funds from the Province Government.

In April 2006, the Provincial Director of Health had explained that DPSL was negotiating with the Provincial Government to obtain a part of the provincial budget to secure the normal functioning of the Health Centres after the phasing-out of the Sida support. These negotiations seem to have been fruitless, but in November managers at the Health Centres were hoping for funds from DPSL for 2007.

One year later, in April 2007, the team could surprisingly enough verify that the Health Centres in the province had got their own budget. It is managed by the District Health Section, and never reaches the

[19] The structure of the health sector in Luanda is undergoing change, and hospitals are upgraded to provincial or general hospitals, which means funding directly from the MoF.

[20] The Portuguese term *comparticipação* means "sharing".

Health Centres directly. Each Centre has to request funds for each specific purpose, but even with the District Health Section as a "middleman", and with budgets that are still insufficient in relation to the accumulated needs, this reform is an important step to improve the functioning of the health system in the province. The centralized system practiced until now seems to have hampered capacity development and initiative among the administrators of Health Centres and Hospitals. With the right support to the administrative directors, this decentralization can be the start of an interesting and productive development. The new budget system is first tried in Luanda, and the aim is to implement it gradually in the rest of the country.

**Table 2. Estimated expenditures (USD) per programme and institution for 2007.**

| Programme/Institution | Budget/Expenditure 2007 |
|---|---|
| Maternal and Child Health Programme | 300,300 |
| Immunization Programme | 193,000 |
| Essential Drugs Programme | 380,200 |
| Project for Combating HIV/AIDS | 585,100 |
| Provincial Directorate of Health of Luanda | 53,000 |
| Cajueiros General Hospital (2nd level) | 43,100 |
| Kilamba Kiaxi District Hospital (2nd level) [21] | - |
| Kazenga District Health Section | 28,300 |
| Cacuaco District Health Section | 18,500 |
| Ingombota District Health Section | 14,000 |
| Maianga District Health Section | 17,000 |
| Kilamba Kiaxi District Health Section | 12,400 |
| Samba District Health Section | 17,000 |
| Sambizanga District Health Section | 17,000 |
| Rangel District Health Section | 9,300 |
| Viana District Health Section | 20,200 |

*Source:* DPSL, 2007

The above budget calculation is based on the monthly budget established for January 2007 and must not be taken literally, but just as an illustration of approximate budget levels. Considerable increase had taken place already in April 2007, and DPSL's April budget was, for example, USD 104,400. Hospitals and Health Centres were also supposed to get a 100 per cent budget increase from April, but this information had not reached the Health Units. Instead, hospital administrators were complaining about the budget cut by 15 per cent that was suddenly made in October 2006 by order from the MoF (see below).

According to the Director of DPSL, Dr. Vita Vemba, the budget for Health Centres and the three Hospitals Kilamba Kiaxi, Cajueiros and Camama was doubled from the second quarter 2007 (compared to January–March). Budgets are also supposed to increase year by year, to make it possible to decrease and finally eliminate *comparticipações* from the patients.

Health Centre and Hospital administrators were not fully aware of the new budget situation, and had not received the good news about the budget increase in mid-April 2007. This looks like another example of the information gap between the different levels of the health system in the province.

The new system is built on an indicative budget which goes to DPSL, to be redistributed to the Hospitals and the TB Dispensary and to the nine District Health Sections. The annual allocation is distributed per month and the districts receive different amounts according to their population.

[21] According to personal communication, Kilamba Kiaxi has the same budget as Cajueiros Hospital.

Although the budget situation undoubtedly has been steadily improving during the last few years, the budget instability causes a major problem for the administrative directors and health staff at Hospitals and Health Centres, since any Health Unit is extremely vulnerable because of the underdeveloped infrastructure, irregular (or non-existing) maintenance of vehicles and other equipment, power cuts which means extra costs for diesel, etc., etc.

# 9. Institutional Sustainability

CAOL *(Coordenação do Atendimento Obstétrico da Província de Luanda)* and CAPEL *(Coordenação de Atendimento Pediátrico de Luanda)* no longer exist as projects, but remain as coordination bodies within DPSL. The former CAOL and CAPEL coordinators are continuing their tasks within the DPSL structure as Head of Section for MCH (Dr. Isabel Massocolo) and Director for PHC (Dr. Isilda Neves). Compared to the somewhat stressful situation in April 2006, just after the ending of the Swedish support, our impression one year later is quite positive, since activities are running at DPSL in a perfectly normalized way.

Already from the beginning of 2004, the courses for training of nurses to become "specialized midwives", *Curso de Especialização de Parteiras* (CEP), is funded by the Department for Human Resources of the Ministry of Health (MoH) and is part of the new (reformed) vocational training institution ETPSL *(Escola Técnica Profissional de Saúde de Luanda/* Luanda Technical Vocational Health School). The course was never the responsibility of DPSL, but it developed within the scope of the support to maternal health and the efforts to reduce maternal mortality in the province. CEP, that was doomed to be totally unsustainable in its present form in the 2003 evaluation *(Karlsson, et al., 2003)* was, ironically, the first project to become fully funded by the Angolan government and integrated into the education system.

# 10. Service Delivery – Findings

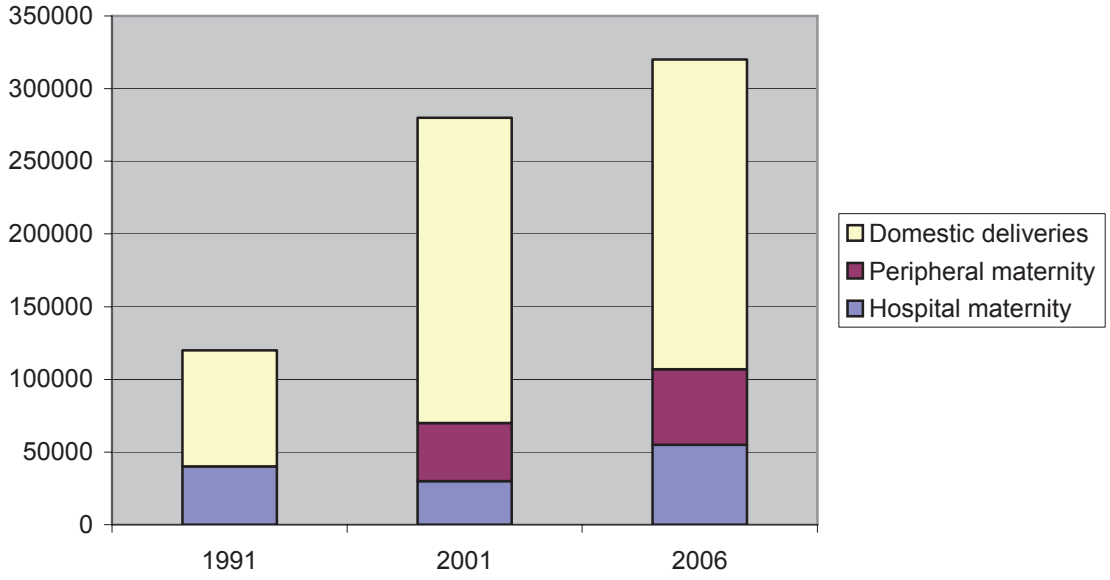
## 10.1 Maternal Health

*Number of deliveries*

Given the questionable quality of data collected by different institutions and organizations through the years, it is not possible to give a very precise picture of the number of deliveries in Luanda. It goes without saying that there are no reliable figures on domestic deliveries, since families do not always register their children immediately after birth and infant deaths might also occur without being recorded. The increasing tendency of institutional deliveries – at Hospitals and Health Centres – should be seen in the light of the uncertainty regarding demographic data for Luanda.

*Figure 3* gives a graphic illustration of the deliveries in Luanda during the same period. In 1991 there were still no delivery wards in the suburban areas (except from possible private clinics about which there is no information). The estimated population in Luanda Province was 2 million in 1991, 4,5 million in 2003 and 5,3 million in 2006.

**Figure 3. Deliveries in Luanda Province 1991, 2001 and 2006***

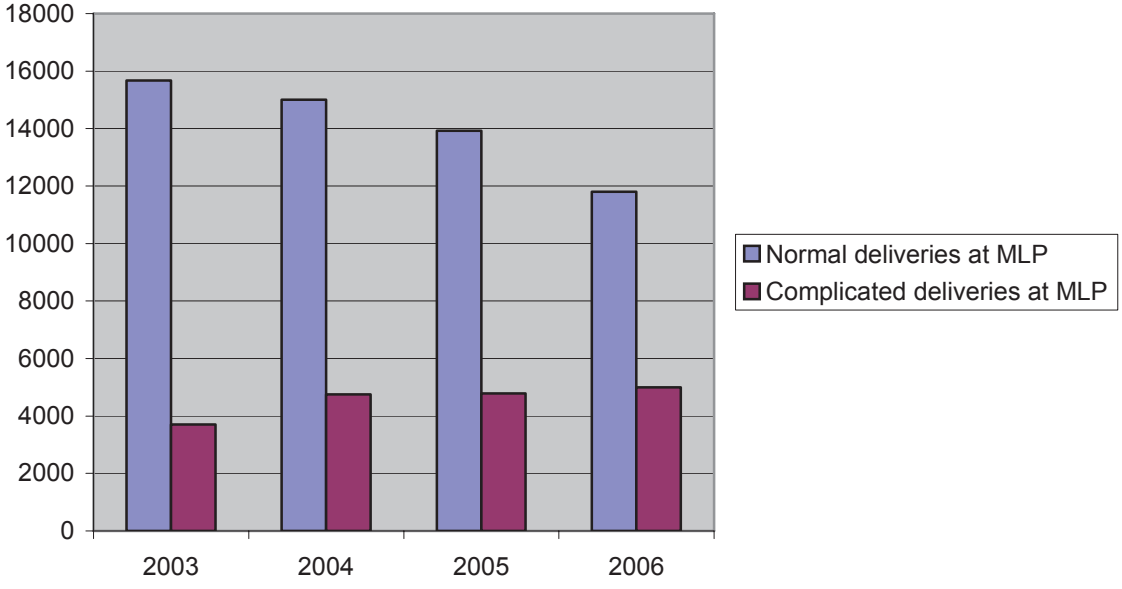



*The statistics from Luanda hospitals include the district hospitals Cajueiros and Kilamba Kiaxi, the provincial Augusto N'Gangula Hospital and the national Lucrécia Paím Hospital.

*Source:* DPSL, 2007

The national Lucrécia Paím Hospital (not under the province administration) had a total of 16,788 deliveries during 2006, and although it is a 1st level reference hospital, supposed to take care of high risk deliveries, the absolute majority of the deliveries are normal (11,795).

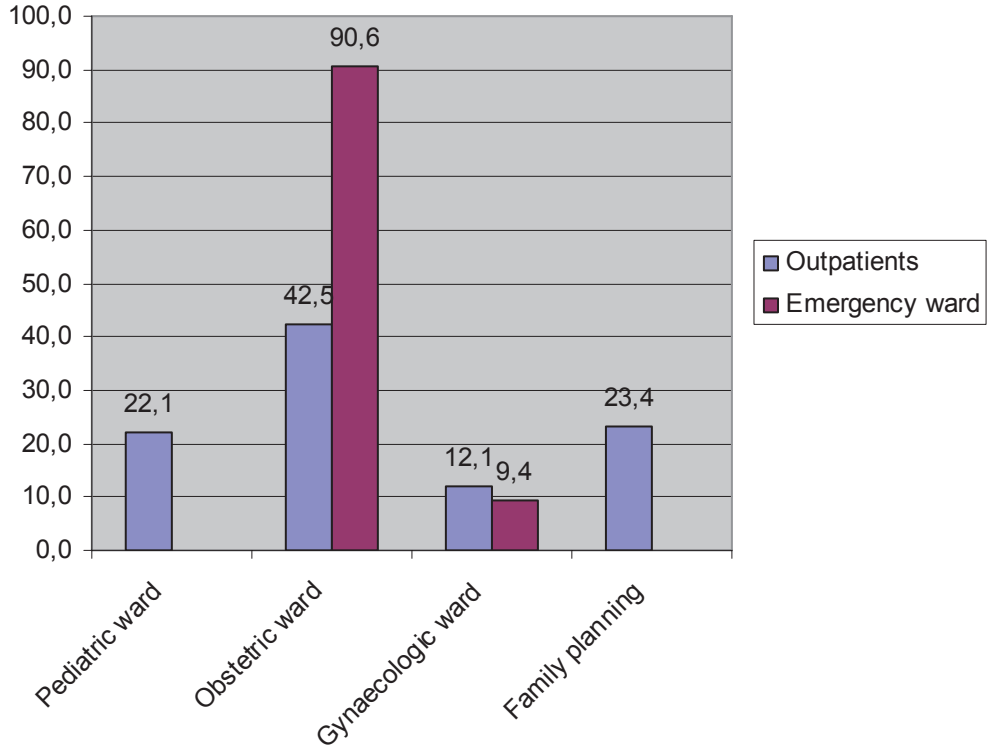
**Figure 4. Distribution in absolute numbers of deliveries at Lucrécia Paím Hospital**




*Source:* Lucrécia Paím Hospital, 2007

We do not have the exact numbers of normal/complicated deliveries at Augusto N'Gangula Hospital, which is formally a 2nd level reference hospital under DPSL, but according to information from staff the pattern is similar to that of Lucrécia Paím Hospital.

**Figure 5. Consultations at Augusto N'Gangula Hospital in percentage (child health, obstetrics, gynaecology and family planning) year 2006.**




*Source:* DPSL, 2007

Augusto N'Gangula Hospital had 37,075 obstetric consultations in 2006, which include antenatal care and deliveries, 6,255 gynaecologic consultations and 7,392 family planning consultations. The absolute majority of obstetric consultations were of emergency character, which means patients referred from Health Centres or district Hospitals or arriving direct from home.

*Decentralized services*

In 1999, the reported number of institutional deliveries at peripheral delivery wards was 55,992 and three years later it had increased to 82,250 *(Karlsson et al., 2003)*. In 2006 the number of institutional deliveries at the suburban Health Centres has decreased to 52,744 (after having deduced the number of deliveries at Hospital do Kilamba Kiaxi).

**Table 4. Number of deliveries at Health Centre delivery wards in Luanda province 2006, per district**

| | Deliveries | | | | | Total deliveries |
|---|---|---|---|---|---|---|
| District | Normal | Caesarian section | | | Forceps | |
| | | 1st time | Return | Total | | |
| Cacuaco | 6,118 | 0 | 0 | **0** | 0 | **6,118** |
| Cazenga | 14,255 | 0 | 0 | **0** | 0 | **14,255** |
| Ingombota | 1,143 | 0 | 0 | **0** | 0 | **1,143** |
| K. Kiaxi * | 16,593 | 835 | 190 | **1025** | 282 | **17,900** |
| Maianga | 4,023 | 0 | 0 | **0** | 0 | **4,023** |
| Rangel | 2,703 | 0 | 0 | **0** | 0 | **2,703** |
| Samba | 7,041 | 0 | 0 | **0** | 0 | **7,041** |
| Sambizanga | 2,765 | 0 | 0 | **0** | 0 | **2,765** |

| | Deliveries | | | | | Total deliveries |
|---|---|---|---|---|---|---|
| District | Normal | Caesarian section | | | Forceps | |
| | | 1st time | Return | Total | | |
| Viana | 6,664 | 0 | 0 | **0** | 0 | **6,664** |
| **Total** | **61,305** | **835** | **190** | **1,025** | **282** | **62,612** |

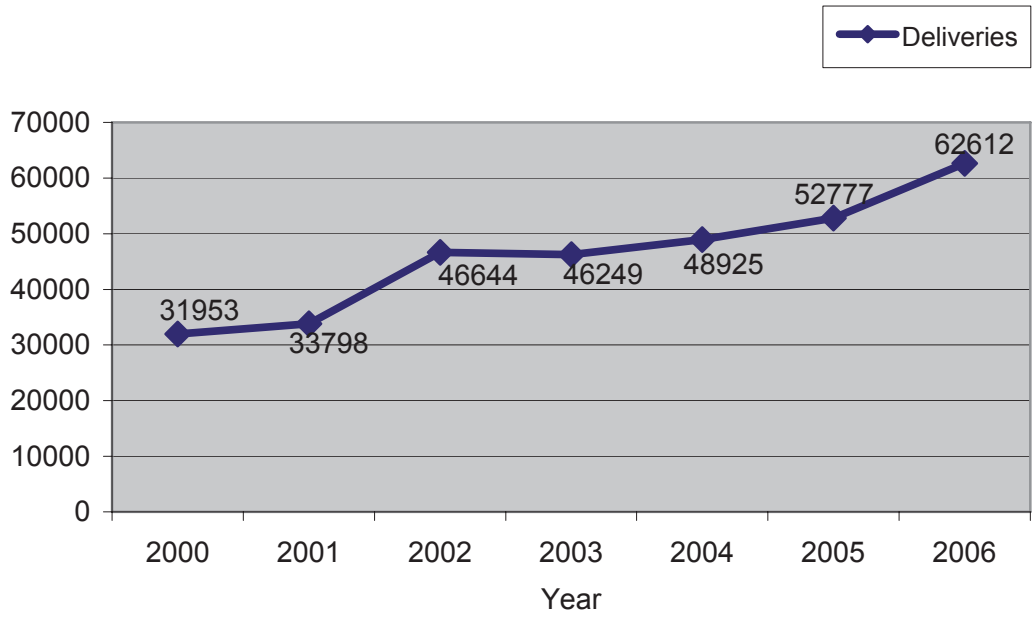
*) Includes 9,868 deliveries at Kilamba Kiaxi Hospital.

*Source:* DPSL, 2007

The above table and *figure 6* below are compiled by DPSL's Department for Studies and Planning and are based on data collected from the Health Centres (including one of the hospitals). It is impossible for us to evaluate the accuracy of these recent statistics compared to the numbers presented by the 2003 years' evaluation; we can only conclude that institutional deliveries have increased considerably, during the last six years, although it seems like the number of deliveries at the peripheral delivery wards has gone down.

From the information we have collected during our field visits we can only confirm the statement from the two earlier evaluations *(Andersson-Brolin & Wessel, 1999, and Karlsson et al., 2003)* that the suburban delivery wards are clearly underutilized in spite of the population increase in the province. We have, however, no real explanation for this development. From what we been able to observe, there is no particular negative trend in the quality of care. One possible reason can be the prices charged at the Health Units, the so called "anarchic fees", which we have confirmed in several cases. If there is a poster on the door of the delivery ward saying that childbirth costs Kz 500 – and the pregnant woman does not know what other costs she might have for gloves, drugs, etc. – such a Health Centre might loose "clients" since few Angolan women are used to the "luxury" of having their children with the assistance of trained nurses or midwives. Another reason is, of course, the access in terms of distance and transport.

**Figure 6. Development of the utilization of the delivery wards at Health Centres*, number of deliveries 2000–2006.**




* The correct number should be 52,744 deliveries after deducing deliveries at Kilamba Kiaxi Hospital.

*Source:* DPSL, 2007

*Maternal mortality*

The rationale for supporting maternal health (and later child health) in Luanda was the promotion of "safe motherhood", i.e. safe deliveries, as a means of bringing down the maternal mortality in domestic as well as institutional deliveries. When support to CAOL started in the beginning of the 1990s, the intrahospital Maternal Mortality Ratio (MMRi) was estimated at 1,010 per 100,000 live births at the two big maternity hospitals in Luanda (1991). The overall objective defined by CAOL was to reduce MMRi to 400 per 100,000 live births. From the data we have collected, it is clear that MMRi in Luanda has been reduced since the early 1990s, but the numbers of recorded maternal deaths are still extremely high.

Statistics on MMRi are not very reliable and there are no data at all on maternal deaths in domestic deliveries, which are estimated to represent 70 per cent of all deliveries in the province. The maternal mortality at the peripheral delivery wards (Health Centres) is very low, since complicated deliveries are referred to the 2nd or 1st level referral hospital. The following table shows the evolution of maternal mortality in Luanda hospitals after a ten years' period of support to CAOL.

**Table 5. Maternal Mortality in hospitals in Luanda province 1999–2002**

| | 1999 | 2000 | 2001 | 2002 |
|---|---|---|---|---|
| Lucrécia Paím Hospital (1st level) | 2,046 | 1,787 | 1,934 | 1,778 |
| Augusto N'Gangula Hospital (1st level) | 950 | 1,176 | 1,097 | 773 |
| Kilamba Kiaxi Hospital (2nd level)* | 100 | 15 | 37 | 453 |
| Cajueiros Hospital (2nd level) | 0 | 45 | 270 | 381 |
| **Per 100,000 live births, total in Luanda** | **834** | **742** | **883** | **688** |

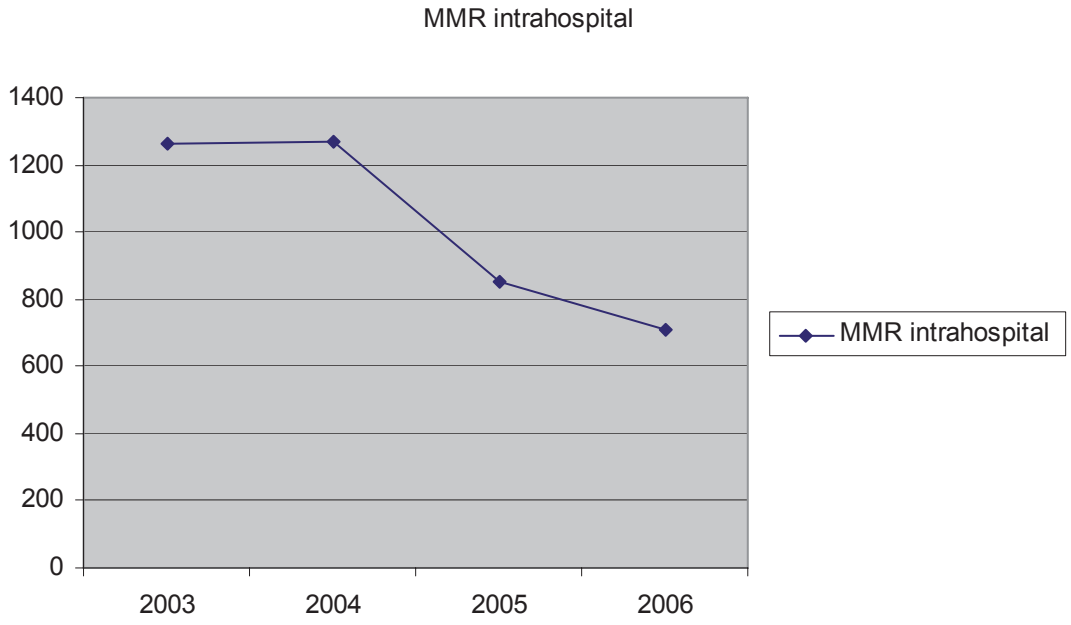
*Kilamba Kiaxi Hospital was undergoing rebuilding during this period and had few deliveries.

*Source:* Karlsson et al., 2003

*Table 5* illustrates the development of the maternal mortality at the referral hospitals. When studying these numbers it is important to understand the reality behind them. The biggest hospitals, i.e. Lucrécia Paím and Augusto N'Gangula Hospitals, are still overburdened with normal deliveries, although they are supposed to receive the most complicated cases that cannot be treated at the district hospitals Cajueiros and Kilamba Kiaxi. The chaotic situation is caused by the dysfunctional referral system and the fact that many "low risk" women only seek help at a Health Centre after long hours of obstructed labour or other complications occurring at home. When referrals are delayed because of lack of ambulances or other means of transport, maternal deaths occur at Lucrécia Paím or Augusto N'Gangula simply because patients arrive there too late.

One of the main problems through the years has been to reduce maternal mortality at the 1st level referral hospitals. The most important measure identified was to reverse the situation at the big hospitals, so that they, instead of receiving a majority of normal deliveries, should concentrate their resources and competence in order to take care of the high risk deliveries (see *figure 4* above). This evolution has been very slow, partly because these two hospitals are located in the city and are under pressure from a large part of the Luanda population since the other public hospitals in the city have no delivery wards. These hospitals are old and well-known and many pregnant women prefer to have their child there, although they have not represented "safe motherhood" or been very "mother friendly" through the years of decay and lack of resources and staff with the right sense of responsibility.

**Figure 7. Development of the number of maternal deaths at Lucrécia Paim Hospital 2003–2006.**




*Source:* Lucrécia Paím Hospital, 2007

Information from Augusto N'Gangula Hospital also shows a considerable decrease of the maternal mortality over time (although it gives the figures per 100,000 live births). This hospital has had 15–17,000 deliveries per year since 2000, with an increase during the last few years. According to Dr. Jerzy Niekowal, the maternal mortality in 2001 was calculated at 1,097/100,000 and had decreased to 526/100,000 in 2004 *(Personal communication 2006)*. According to the DPSL statistics 2006, Augusto N'Gangula Hospital had 19,616 deliveries and an MMRi of 683 (134 maternal deaths). However, it was impossible for us to discuss the reasons behind the MMRi increase since 2004, and the fewer deliveries per year do not explain the mortality increase since 2004.

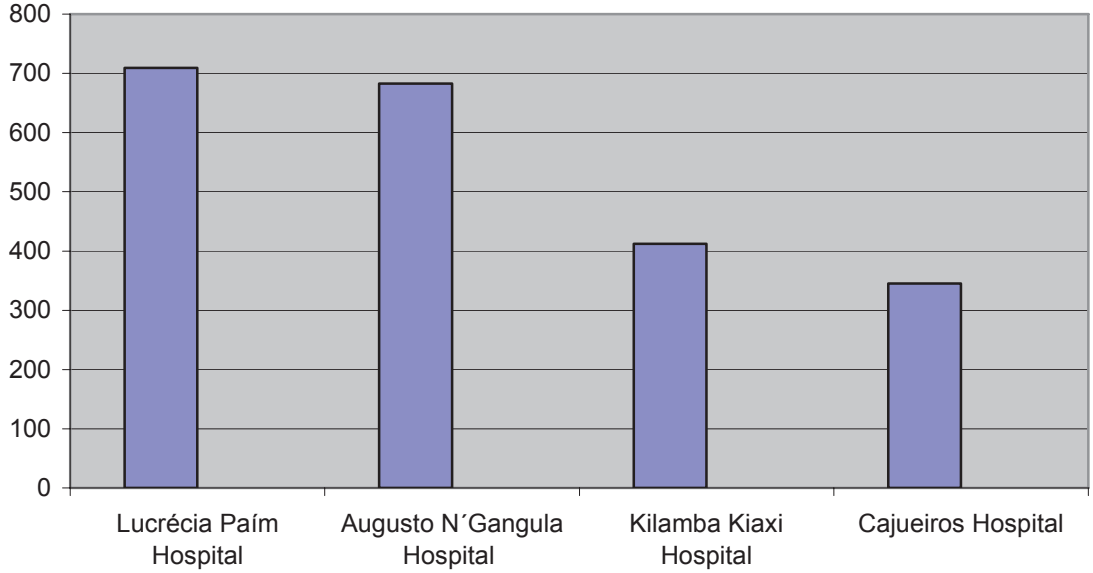
At Hospital do Kilamba Kiaxi 46 maternal deaths were recorded, while Hospital dos Cajueiros had 26. The total number of deliveries at these three hospitals that come under DPSL was 38,350, which means that the MMRi in 2006 was 537. *(DPSL, 2006 p. 45)*

The maternal mortality in all studied hospitals is shown in *figure 8* next page:

Most maternal deaths have causes that are preventable with a well-functioning antenatal and perinatal[22] care, and many women can be saved with an efficient referral system *(figure 9)* from Health Centres to a 2nd or 1st level referral hospital. Sida has helped establishing specialized care of eclamptic patients at Lucrécia Paím and Augusto N'Gangula Hospitals, and it is equally possible for the district hospitals to threat such cases. This has substantially increased the survival of patients with eclampsia, but we could unfortunately verify that the ward for eclamptic patients at Lucrécia Paím Hospital was closed due to the lengthy ongoing reconstruction works. For patients with other serious complications, such as haemorrhage and malaria, quick transfer to one of the hospitals is crucial, but it is a well-known fact that many women die while waiting for transport or in the ambulance because of the chaotic traffic situation in and around Luanda city.

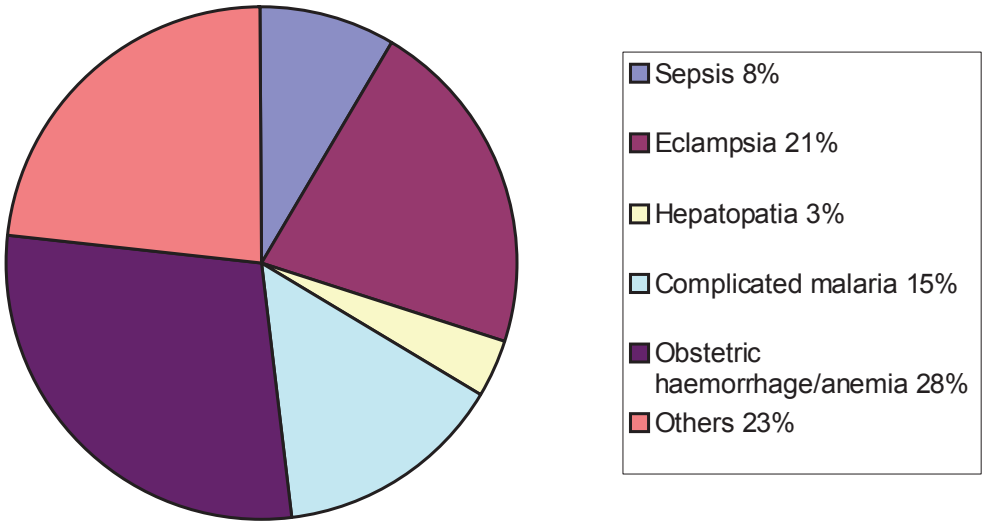
[22] Perinatal care includes mother and child up to approximately one week after childbirth.

**Figure 8. Maternal mortality (per 100,000 live births) in Luanda Hospitals 2006**




*Source:* Lucrécia Paím Hospital and DPSL, 2007

**Figure 9. Maternal mortality in Luanda hospitals, fatality rate 2006.**




*Source:* Lucrécia Paím Hospital (interview) and DPSL, 2007

It will still take an extremely lengthy systematic effort before the goal 400/100,000 can be achieved since the maternal health situation in Luanda (and, naturally, in the rest of the country) is dependent on a complexity of factors, such as family planning, health education, antenatal care, trained midwives and other health staff, better access to delivery wards, a functioning referral system and an alert perinatal care.

A very positive initiative is the National Strategy for the Reduction of Maternal Mortality and the creation of province and district Committees to Reduce Maternal Mortality. Such a Committee includes health professionals from the maternal health area, representatives of the women's organization OMA *(Organização da Mulher Angolana),* local community and civil society representatives, Traditional Birth Attendants (TBA) and others who can contribute to reorganization of the obstetric care at local level and participate in community based health education activities, etc. A few such committees have slowly started functioning in the province, e.g. in Kazenga and Cacuaco. Thanks to the concerted action of the Committee, 60 women in Cacuaco district have lately been referred to either the Health Centre or to the hospital in Luanda to eliminate the risk of dying during delivery.

## 10.2 Antenatal Care and Family Planning

*Antenatal care*

Investment in antenatal care and family planning was one of the strategies from the beginning to improve maternal health and, as a result, reduce maternal mortality. According to available statistics, the number of antenatal consultations has increased annually, but coverage is still considered to be too low.

In 1999, the officially estimated coverage of antenatal care was 87 per cent, a figure which was most certainly too high. A more reliable estimate at the time was supposed to be around 50 per cent *(Andersson-Brolin & Wessel, 1999)*.

In its final report to Sida, delivered in 2006, CAOL presented the following figures:

**Table 6. Antenatal care in Luanda 1999–2005**

| | 2001 | 2005 |
|---|---|---|
| Estimated no. of pregnant women* | 288,141 | 319,295 |
| Antenatal care, total consultations | 345,403 | 524,365 |
| Antenatal care, 1st consultation | 157,158 | 214,580 |
| Antenatal care, return consultation | 223,283 | 309,785 |

* 6.1% of the estimated population

*Source:* CAOL, Annual Report 2005/2006

Towards the end of 2005, there were 87 rooms distributed over Health Centres and the smaller Health Posts providing antenatal care. We do not have the exact figure for 2007, but there is certainly not lesser possibilities for pregnant women to get antenatal care. Today, DPSL reports a total number of 431,626 consultations at Health Centres and Posts *(DPSL, 2007)*, and the average number of consultations oscillate between 0.4 (Ingombota in the city) and 3.2 (Cacuaco in the northern part of the province). 99% of these pregnant women were seen by a nurse, which might cause many women to abandon the Health Centre for one of the referral hospitals hoping to be checked by a doctor (which usually does not happen).

There are no data available regarding the proportion of pregnant women immunised against tetanus. Yet, it is a well-known fact that pregnant women do not always get full immunity against tetanus, mainly because they come to their first antenatal consultation too late to get the two doses of vaccine needed. Consequently too many newborn children die from neonatal tetanus. The number of cases is slowly coming down, but the Paediatric Hospital receives several cases per year. There is, in all probability, a huge number of unrecorded cases, since the infection usually appears after domestic deliveries and traditional treatment of the umbilical cord.

Control of HIV and syphilis are not included in the clinic routines, although some Health Centres advice women to take a HIV test, especially when nurses suspect a woman to be infected.

The standard card for antenatal care from the MoH is relatively new and includes all important factors to identify possible risk pregnancies, and lists all necessary drugs such as iron, folic acid and cloroquine for malaria treatment (although the new malaria drug Coarten has been introduced recently). Anti-tetanus vaccination is equally included, with the dates for the minimum two doses needed. All risk factors are included, for the midwife or nurse to evaluate the obstetric risk level and help the woman to plan for a hospital delivery if needed. The symphysis-fundus height of uterus is in absolute numbers correlated to weeks of pregnancy and a diagram would, thus, be better for monitoring of foetal growth and detection of twins.

The quality of antenatal care is probably quite varying, especially during periods when there is a lack of essential drugs. We have understood that blood pressure is not always checked, and that other risk factors might be overlooked. But since quite a lot of women utilize the antenatal services, they certainly serve a purpose, both for women who opt for delivery at the Health Centre and for those who prefer to have their child at home.

*Family planning*

Family planning services are working at all visited Health Centres. The number of visits has, however, declined and DPSL reports only 89,305 visits during 2006 at primary level Health Units. There is no clear explanation for this, but those who work with reproductive health mean that attitudes among the Angolan people are extremely pro-natalistic, which is also reflected in the very high population growth. According to MICS (Multiple Indicator Cluster Survey) 2003, the fertility rate is, on average, 7 live born children per woman.

**Table 7. Family planning in Luanda 2001–2007**

| | 2001 | 2005 | 2007 |
|---|---|---|---|
| Family planning, total consultations | 124,108 | 167,896 | 89,305 |
| Family planning, 1st consultation | 32,388 | 45,718 | 26,109 |

*Source:* CAOL, 2006 and DPSL, 2007

A relatively new family planning service for adolescents is less spread but is considered quite successful by health staff, since young people can go there and get contraceptives for free. From the available statistics it is not possible to separate these services from the general family planning services, and data only include visits which have resulted in handing out contraceptives or pills, and giving injections (Depo-Provera), IUDs, etc.

Although counselling is not included in the statistics, what was before simply family planning in the sense of "birth control" has today developed into reproductive health with services that are quite comprehensive and include STD/HIV prevention, counselling on infertility, and sex education for young people. Some male health staff have also been recruited to work at the family planning units.

## 10.3 Counselling and Treatment of HIV Infected Patients

Among the visited Health Units Ana Paula Health Centre, Asa Branca Health Centre and the Cajueiros and Kilamba Kiaxi Hospitals receive and treat HIV infected pregnant women and their children after delivery. Ana Paula Centre has recently (2006) started counselling with a doctor on duty daily from 8.00–15.30. Cajueiros receive 1–3 new cases per week (first consultation), and the number tend to increase. This is explained by the fact that the stigma among women seems to be less nowadays and also by the fact that the service is becoming more widely known.

Seropositive mothers are referred to have their children at one of the Hospitals. Contrary to common practice, the district hospitals do not use caesarean section but normal delivery under especially regulated conditions. Mothers are treated with ARV drugs before delivery and babies are treated immediately after birth. According to the information gathered, no baby has been infected as far as the hospitals know. Mothers are usually instructed not to breastfeed, and can get milk formula for free but it is not known whether or not they follow these recommendations. Children are medically checked up to 1½ year of age and are then declared fit.

Like the aforementioned Health Units, Kilamba Kiaxi Hospital makes voluntary HIV tests of patients when health staff may suspect a possible HIV infection. (Whether tests are "voluntary" or not is a debatable point.) The Hospital is part of the national Programme to Combat HIV/AIDS since 2004. The following results of HIV testing refer to the first quarter 2007:

**Table 8. Results of HIV tests, Kilamba Kiaxi Hospital, 1st quarter 2007**

| | No. tested | Seropositive | Negative | Indefinite |
|---|---|---|---|---|
| Pregnant women | 1,136 | 43 | 1,091 | 2 |
| Non-pregnant women | 128 | 29 | 99 | 0 |
| Men | 8 | 0 | 8 | 0 |

*Source:* Kilamba Kiaxi Hospital (interview)

Dr. Luís Bernardino, Director of the Paediatric Hospital David Bernardino, however informed that the HIV prevalence is rapidly increasing. Ten years ago, the prevalence of HIV among patients was 1%, while today it has already reached 15%. 600 children are presently (2007) under ARV treatment.

Randomly collected data on HIV infection tend to indicate that HIV is no longer as inoffensive as the official figures on prevalence show (below 3% in the population on an average). It is well-known that prevalence is far higher in provinces bordering the DR Congo, Zambia and Namibia and with the limited outreach of health services and equally limited testing capacity, the perspectives seem rather alarming.

## 10.4 Child Health

If one can say that the peripheral delivery wards are still underutilized, this is certainly not the case regarding the paediatric wards at the Health Centres. They are supposed to function as emergency wards, open 24 hours per day, and they are usually very crowded. So far we could only monitor activities during the daytime, and we can at least confirm that work goes on until late in the afternoon.

Generally speaking, paediatric health services are the most procured of all simply because children often get sick – malaria, respiratory infections and diarrhoea are the most frequent diseases. Health Centres with paediatric wards (reference Health Centres) have a few beds to keep sick children for observation or for treatment, e.g. rehydration.

**Table 9. Paediatric health services in Luanda 2003–2006, children 1–14 years***

| | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|
| Reference Health Centres | 259,236 | 234,901 | 212,388 | 856,852** |
| District Hospitals | 51, 544 | 41,788 | 90,782 | 76,054 |
| Augusto N'Gangula Hospital*** | - | - | - | 7,001 |

* Data for 2006 not specified per age

** All Health Centres and Posts

*** Paediatric ward at Augusto N'Gangula Hospital inaugurated in 2006

*Source:* CAPEL (draft), 2006, DPSL, 2007

In its annual report 2006, DPSL estimates the population 0–14 years at 2,825,000. According to DPSL's data for 2006, children aged 1–4 years dominate (38.6% 2006) at the paediatric wards followed by <1 year (35.8%) and 5–14 years (25.6%). Of the children below one year, 752,396, are taken by their parents to the Health Centre to check weight weight, representing 0.2 visits per child.

From the data presented in reports from CAPEL and DPSL it is not possible to draw conclusions about the functioning of the referral system. In the CAPEL report for 2003, these data exist, showing that 1,983 transferrals were made to a district hospital (Cajueiros or Kilamba Kiaxi), while 1,596 children were referred to Paediatric Hospital David Bernardino. The numbers in the table thus stands for direct consultations at the three hospitals.

Paediatric care, as well as the rest of the health system, is managed mainly by nurses (female and male). During the existence of the CAPEL project quite a big effort has been made to train nurses according to the programme for Integrated Management of Childhood Illness (IMCI) and today there is a staff of well-trained paediatric nurses spread throughout the Health Centres in the province.

We have not been able to collect data on <5 mortality, and the DPSL report unfortunately does not include any for 2006. The final report (draft) from CAPEL, in 2006, in fact underlines that not even the statistics recorded at the hospitals can serve as a basis for evaluation of the evolution of infant/child mortality within the health system. According to MICS 2003, the (estimated) infant mortality is 150/1,000 while <5 mortality is as high as 250/1,000 (data for 2001). Nothing indicates that this alarming situation would have changed significantly in Luanda, since the majority of the child population is not reached by the health services for immunization and care.

Immunization continues to be a problem, and only the BCG vaccination has a relatively good coverage. Immunization is handled by EPI, which certainly continues functioning as a vertical programme, but exists at practically all Health Centres. Still, some districts report only 37% coverage of BCG vaccination. BCG used to be the only vaccination given to practically all children since it is a well established practice since colonial times to take your newborn child to the Health Centre to get the vaccine also after domestic delivery. Also coverage of DTP and polio (all three doses) is very low. There is actually no real explanation for this fact and, worst of all, it is not at all a new situation – it goes back through the decades of EPI's presence in Luanda.

## 10.5 Supervision

The Health Centres continue to receive monthly supervision/quality monitoring visits from DPSL staff. The quality monitoring programme is managed by the PHC Director, Dr. Isilda Neves. Midwives at Ana Paula Centre in Viana, for example, mention monthly meetings with the Head of the MCH section, Dr. Isabel Massocolo and all the other Centres mention that supervision is maintained, although at irregular intervals. It has not been possible to find any data regarding supervision, but we have reason to believe that activities continue at a lower pace than during the CAOL/CAPEL project times.

## 10.6 Day-to-day Activities

It is evident that the absence of external support has had some negative effects on the service delivery, although it is difficult to isolate the effects directly related to the phasing-out period.

We were unable to study possible negative effects for beneficiaries, but from what we have observed during the three field visits, activities are running normally and smoothly at the Health Centres. The complaints about lack of drugs and non-working equipment did not seem to affect nurses and midwives in their work with women in labour or sick children. At all the visited Centres the atmosphere was calm and friendly, and staff seemed to perform in a fully professional way.

In November 2006, the Ana Paula Health Centre in Viana was, for example, visited on a Friday afternoon; activity was rather low in the delivery room and in the paediatric ward.

Hoji ya Henda and Asa Branca Centres were visited on a Monday morning, and were naturally more crowded. At Hoji ya Henda staff reported from the night shift: 5 deliveries, no transferral, and 7 children at the paediatric emergency room. At the Asa Branca immunization and nutrition monitoring were working very efficiently.

Cajueiros Hospital was visited on a Monday afternoon. The delivery ward received a patient transferred from Asa Branca in a life-threatening condition. She was immediately put under treatment, approximately 30 minutes in all including the short distance transport by *candongueiro,* and after haemorrhage was stopped she regained consciousness.

## 10.7 Illegal and Legal Fees

The team has tried to check on fees paid by women and parents for reproductive and child health services, but it has not been possible to collect information from patients/parents at the Health Centres. Directors at DPSL and at Health Units make no secret of the fact that illegal fees are frequently charged in Luanda since many years back. The problem with *gasosas* has been underlined by Sida commissioned evaluations in 1999 and 2003 as constituting a serious hindrance to women/parents/youth to make use of the available health services.

In April 2006, the Ana Paula Health Centre in Viana had a poster on the door informing that the fee for delivery was 500 Kz, but this poster was no longer there in November… At Hoji ya Henda the administrator stated that delivery was free of charge, but admitted that it would be very difficult to finish with the *gasosas*. Later we were able to observe how mothers handed over the folded immunization card with a Kz note inserted. Needless to say, immunization of children is free… Emergency wards are not allowed to charge for paediatric consultations, but do so nevertheless. Essential drugs – cloroquine, Coarten, antipyretics, antibiotics, etc. – should be distributed free of charge, but are often sold to patients.

The *comparticipações*, i.e. the regulated and openly charged fees (not quite clear if this is legal or not) are announced at the reception desk. A normal consultation costs 200 Kz (appr. USD 2.5), while blood tests and other tests have a special price list. Malaria tests are free. These revenues make it possible to run the Health Centres, and e.g. Asa Branca receives an average of 50,000 Kz/day, and at least 1 million Kz/month, which is used to purchase drugs, detergents, fuel, spare parts, foodstuffs, etc.

The Health Centres confirm that their situation was more amenable during the CAOL/CAPEL period; now it is extremely difficult to make ends meet when they exclusively depend on the *comparticipações*.

# 11. CEP – Course for Specialization of Midwives

CEP was "taken over" by the Human Resources Department of the MoH in 2004, after Sida had frozen the disbursements to the course. Since students come from places outside Luanda and have to be on leave to study in Luanda, the MoH made an effort to quickly guarantee the resources needed to keep the course going.

The course has had considerable material resources through the years, and certainly feels the difference with the much less generous budget from the MoH.

Since the start in October 1998, 92 midwives have graduated from the four courses run by CEP. 41 of the students come from Luanda, while 51 come from twelve of the other eighteen provinces. 47 of them have returned to their workplaces as midwives – delivery wards at the Provincial Hospital or Health Centres – while four of them continue as teachers at CEP in Luanda or in Malanje and Lubango *(CEP, 2007)*. Two of the midwives from the first course continued studying the university course in nursing, and are today employed at the General Hospital of Luanda (Camama) and at the Lucrécia Paím Hospital.

In 2006, three courses were in progress. Besides Luanda, the first courses had started in Malanje and Lubango (Huíla Province). 27 nurses were studying in Luanda, 15 in Malanje and 25 in Lubango.

The staff is small, only six persons including administrative personnel, and CEP has requested more staff from the Department of Human Resources, first of all another specialized midwife and one obstetrician for teaching.

The course lasts 52 weeks, of which 780 hours are dedicated to lessons (theory) and 1,290 hours to practice at some of the Health Centres and at the 2nd level Maternity Hospitals. (CEP has problems placing their students at Lucrécia Paím Hospital.) Besides the maternal and reproductive health part of the course, there is also a part covering information, health education and communication that is lectured by sociologists, anthropologists and psychologists. The teachers work with modern pedagogical methods, such as role play and drama and problem-solving through team work.

In 2007, CEP and the MoH decided to stop recruiting students for the courses in Malanje and Lubango since the small group of teachers could not cope with the situation and moreover the premises in Malanje were not ready. But work in the provinces has been running relatively smoothly, in spite of teachers having to travel from Luanda to these province capitals. The CEP coordinator, Dr. Engrácia de Freitas, describes the MCH development in the provinces in very positive terms. Both provinces are building up a decentralized system with small delivery wards at existing Health Centres, and the support for CEP is very strong since there is a common understanding that an increased number of trained midwives are urgently needed.

It has not been possible to evaluate the quality of CEP and its course, but we have heard several specialized midwives confirm that the quality is good and that this course has given them a high degree of professional security which, in fact, was the underlying goal when Sida started discussing support for building up modern midwifery training in Angola.

# 12. Future Sustainability

After the visit to Luanda in November 2006, we were convinced that the most burning issue for the near future was the lack of financial resources set aside for the (public) health sector in Luanda. At the end of 2006, the budget situation for the primary level (Health Centres) had not been solved and even the provincial and general hospitals had a virtually absurd situation since their "indicative" budgets were transformed into periodically disbursed funds that could be drastically cut from one day to the other.

During the last visit, in April 2007, we could, surprisingly enough, confirm that one of the most important preconditions for institutional sustainability has been fulfilled. The development towards a more decentralized management of the Health Units now depends on the DPSL and its capacity to support and follow-up the evolution of the system. The development of responsibility and competence among the group of administrators and other staff at the health units and, above all, among the staff of the District Health Sections, are crucial factors for success or failure. It rests upon DPSL and its top management to establish immediately ethical norms against corruption and misuse of funds, since many negative practices have passed with impunity through the years. Consequently it is up to DPSL to make every possible effort to create a smoothly functioning budget system and help establish the right priorities so that conflicts regarding the utilization of the resources can be avoided.

Although Health Centres from January 2007 receive a budget through the District Health Sections, administrators and staff were not fully informed about this new situation. These resources will certainly not solve the piled up problems of maintenance and spare parts, let alone emerging emergencies, since all costs have to be processed through the District Health Sections, where administrative staff might have difficulties in coping with the new system in an efficient way. In spite of possible "teething problems" in implementing the budget system, there is no doubt that decentralization of resource management is of great importance to secure not only the functioning of the health system, but also health services of reasonable quality.

A remaining threat is, however, the low and seemingly arbitrary salaries within the health sector. If salaries remain low, and, on top of that, are not paid regularly, there is an obvious risk that health workers fall back into the former routines of not turning up at the workplace and start working more and more in private clinics or establish their own small health business on the side based on stolen drugs and disposables. A decent salary is the most important instrument to induce staff to maintain motivation and continue performing ethically correct and with responsibility. If nurses and midwives start copying the behaviour of doctors who spend more of their professional time in private clinics than in the government-run hospitals, the present decentralized MCH system will soon start to erode. Such a development would not only undermine the entire health system, but also frustrate many years' efforts of competence and quality development to the benefit of the population of Luanda and also to introduce reforms to serve as an example for the rest of the country.

# 13. Negative Effects of the Phasing-out

*Enigmatic phasing-out*

In April 2006, during the first phase of this evaluation, the interviewed persons with positions of responsibility did not voice any severe criticism against Sida for phasing out its support and they appreciated being informed of the phasing-out in sufficient time. There were, of course, feelings of disappointment and a certain anxiety about the future of the activities without InDevelop's rather hands-on support. The only panic-like reaction was around the lack of drugs for the maternal health programme, which was certainly a very serious issue.

Many people however expressed their doubts about Sida's motives for withdrawing from Angola after having been there for such a long time and under much worse circumstances than presently. During the war it was practically impossible to produce any development of the health sector. Why abandon the country when at last it had gained peace and enough stability to really start developing health institutions and improve reproductive and paediatric health services? Later on it became clear that the political motives of the Swedish government to discontinue supporting MCH in Luanda were not at all known by health workers in the field, since only DPSL staff and project coordinators had received information in seminars and workshops when the activities during the phasing-out period were outlined.

It is worth mentioning that we have been unable to fully clarify the process behind the Swedish decision to finalize the support to MCH in Luanda. Documentation is scarce, and none of the persons interviewed in Sweden can give a satisfactory explanation.

*Angolan criticism*

During the first discussions in Luanda, it was difficult to grasp any more profound criticism regarding the phasing-out of the programme. Only very late, in a more unreserved climate, some important objections against the phasing-out procedures were raised. The main point was the very short period given to prepare for taking full responsibility of managing the programme that had come to function on the side of the ordinary DPSL structure. CAOL and CAPEL became classical by-pass projects with their own routines, with their two separated budgets where little flexibility was allowed. CAOL's budget was only for CAOL, even though CAPEL logically could have used part of it for the children. As the former coordinator of CAPEL said: "Obstetricians take care of mothers, but often forget about the child…"

Eventually, the Angolan part also voiced some complaints about the implementation consultant. DPSL actually did not feel involved. During the short phasing-out period procurement of vehicles and equipment had to be quick, and DPSL was not consulted.

These negative statements should however be balanced against some very positive aspects, above all the Swedish advocacy for the need to increase the health budget and to decentralize resources at least to the Province to create certain guarantees for maintaining the achieved level of the MCH services in Luanda. Another strong point was the creation of PAI, which made it possible to boost some aspects of the programme, such as training, and not only facilitate procurement of vehicles and ambulances.

*More software needed*

After reflecting on negative effects, and possible measures of mitigation, we come back to the observation made about the health support as a whole, during almost three decades. One critical remark is that Sida and InDevelop invested too little in "software", in the sense that too little energy was been spent on management methods and training. Management capacity is a crucial factor in creating sustainable systems, and this capacity is in short supply in the health sector in Luanda.

The MCH programme has had a strong medical bias, although it is clear that the basic problems leading to the extreme maternal mortality and child mortality from preventable diseases are, to a very high extent, caused by organizational and systemic faults. These aspects have been overlooked until the very end of the programme.

We have observed that while most medical staff at Centres and Hospitals seem to perform quite well and responsibly under difficult working conditions, the entire health system suffers under the burden of heavy bureaucracy and severe management problems. In Angola the profession health administrator/manager does not yet exist, but is, in fact, urgently needed. As a consequence, a large number of the country's few qualified medical staff are performing management and planning tasks, instead of working as doctors. As far as we have seen, this issue has never been seriously brought up in the discussions between Angola and Sweden through the years.

At the Health Centres – after all, the most important level for the community – very little attention has been paid to the administrative and management sides of the work and relatively big Centres are run without computers in sight and with very primitive methods that make it difficult to develop the Centre and make it function in a more rational way. Directors might have management training and experience, but they have always been circumscribed by nil budget and little modern equipment. Some do not even have files for their documents or a bookshelf where to put possibly existing files.

This problem is not directly linked to the phasing-out decision and implementation, but goes back in history. The same can be said about logistics and maintenance of vehicles and equipment, which is a really burning issue that can jeopardize the functioning of the entire health structure of the Luanda province. The fact that InDevelop organized some training courses in logistics and maintenance during the phasing-out period is certainly commendable. It stands however clear today that this happened far too late to have any real effect. The maintenance team is an unknown factor at the Health Centres, which are at a loss with all their broken down ambulances and generators.

With the management system applied within the programme the DPSL and its different departments were left with too little responsibility. An implementation consultant often tends to behave like a "doer" to speed up things, instead of handing over problems to the level where they belong, in this case to DPSL. This might certainly be more practical, but is usually counter-productive in the long run since it does not imply any real learning process. Today DPSL and the Health Units involved in the former programme are left with the entire responsibility for running activities previously smoothly managed by InDevelop, which made it possible for health staff to work under comparably privileged conditions and with a rather generous budget. Since the decision regarding phasing-out was communicated with short notice, and the phasing-out period had a lot of complications, evidently these faults could not be fully attended to during the phasing-out period and would certainly have needed much more time than less than two years.

*Communication*

Another question mark is the issue of communication between the centre (DPSL) and the periphery (Health Centres). The Health Centres are aware of the end of CAOL and CAPEL as service organizations, but there seems to be a certain lack of clarity about routines, supplies etc., and that DPSL today is the responsible structure when it comes to supporting the Health Centres. Supervision and quality monitoring appear to be running regularly, but the administrative side of the contacts seems to be less developed.

As a final issue, we would like to point out that only few people were actually aware of the phasing-out of the Swedish support, let alone the underlying motives of the Swedish government to terminate the support to MCH in Luanda. For most health workers CAOL and CAPEL just evaporated and stopped distributing drugs and supplying material to Health Centres and Hospitals in the periphery.
Although we do not have a well-founded analysis of the feelings among health workers, we believe that they had the right to be informed about the new situation, which is no longer a project context with incentives and smooth by-pass routines. Health Centres now simply depend on the provincial health structure, which no longer has a problem-solving implementation consultant on its side. Today all health workers again must rely on the District Health section and the DPSL, and learn how to build up a system of communication and exchange of information with these levels. We hope that both those in the periphery and those in the centre will use their professional capacity and creativity to dialogue and make a joint effort to maintain the ground that has been gained during more than ten years of development support in the MCH sub-sector.

# 14. Conclusions – One Year Later

The following conclusions refer to the DPSL and the MCH sub-sector:

*DPSL performing with responsibility*

A main conclusion, and a very positive one, is that, according to our understanding, DPSL has taken its responsibility to continue the work to defend the achievements made during the more than ten years with CAOL and CAPEL and the Swedish support. Committees to combat maternal mortality are created; some more staff has been employed; more resources for health services than ever are available today; the worn down Health Centres and Hospitals have received new equipment and the Cajueiros hospital will soon undergo a thorough repair. Training continues – with or without external support – and supervision and quality monitoring is now working on a relatively regular basis. Services have not broken down, rather the contrary. Five new delivery rooms were established in 2006 and another three are planned for inauguration in 2007.

*Integration*

The former projects CAOL and CAPEL have been successfully (re-)integrated into the DPSL structure. Instead of partly functioning as separate bodies, their staff and resources are, again, part of the PHC programme with its sub-programme MCH, led by the former coordinators (director of the PHC programme and Head of MCH, respectively). This means that the positive effects of the long project period, with capacity building, professional training of crucial staff categories, quality monitoring and supervision, attitude influence, etc. are not being lost, but are assets that can have an impact on all health units in the province. The building up of knowledge and competence is one of the most important effects of the Sida support, and is a valuable platform when the ongoing work to improve the quality of care in the future is supported by the budget reform and other positive developments in the health sector in Luanda.

*Budget reform – a major achievement*

Since the Angolan party had agreed to assure the sustainability of the programme after termination of the external support, the phasing-out period was full of uncertainty. The responsible organ DPSL and its Director, did not succeed in the 2005 negotiations to guarantee resources from the MoF/Province Government to fill the gap after the withdrawal of Swedish support. No other important donor was expected to substitute Sida, and during 2006 there was still no response from the government regarding a decentralized budget to avoid a degradation of the relatively well-functioning MCH activities.

The budget reform is therefore the most important contribution to institutional sustainability. It is actually a condition *sine qua non* to maintain the achieved quality level and to retain the confidence in the services provided by the suburban Health Centres and Hospitals, and, in a long-term perspective, to help reduce maternal and child mortality and, possibly, help restraining propagation of HIV and guarantee treatment of already infected mothers (and fathers if they accept being tested) and their children.

It is indeed interesting to have witnessed how a depressing and uncertain situation immediately after closing down the Sida funded projects, in one year's time was brought around to a situation which has made it possible to normalize the functioning of the provincial health services and to hand over responsibilities to the decentralized levels where they logically belong. Although work at DPSL and at the District Health Sections will certainly not go like clockwork, and problem solving will take time, there is no other way than taking full responsibility before the citizens and users of the public health system in Luanda.

*Retainment of staff*

The fact that staff has not left DPSL and the MCH sub-sector during or after the phasing-out of the support from Sida and InDevelop is a good sign. Yet, DPSL and the MoH cannot just lean back and feel secure that this situation will last forever. If salaries are not adjusted according to people's competence, seniority and training the most qualified staff can easily be absorbed by the private health sector, which would be a loss for the provincial health system that really needs to keep all its competent staff.

*Underutilized delivery wards*

Among the burning issues that remain after phasing-out, although they might not have a direct bearing on phasing-out as such, is the low percentage of institutional deliveries in the Luanda region.
The existing peripheral delivery wards are underutilized, and at least 70 per cent of all deliveries still take place at home. Some studies explain why women prefer to have their children at home, but when the aim is to promote safe deliveries and reduce maternal mortality there is still a lot that needs to be done to analyse the issue and take action to change this situation. To achieve results health workers have to approach the communities and listen respectfully to women's and families' worries around pregnancy and childbirth and adapt services to the needs of the users. Fees are the most important obstacle for poor people to search ordinary health care or to give births at a Health Centre instead of at home without qualified help. Our understanding is that the so-called *anarchical fees (cobranças anárquicas)* is the main reason behind the underutilization of existing suburban delivery wards.

*Remaining weaknesses in obstetrics*

Another weak point is the observed tendency of decreased supervision and follow-up of the use of partogram. Knowledge is a living material, and if midwives do not get the right support and permanent training/reminders they easily drop a method that costs some effort and thinking, but makes delivery safer for the pregnant woman. Obstetrics and well as paediatrics are perishables, and must be kept alive by hands-on training to make doctors and nurses/midwives able to handle obstetric and neonatal emergency situations. Another negative, and dangerous, aspect is the tendency to opt for caesarean section before trying the vacuum extractor, and most midwives are not at all used to that instrument.

*Urgent need for blood bank*

A critical issue, with consequences for the work to reduce maternal mortality, is the lack of a functioning blood bank. Hospitals have small quantities of blood, but seldom enough to save lives of bleeding women after childbirth. The blood bank was originally one of the components of the Institutional Support project, but was lifted out since it was expected to be funded by the EU. This did not happen, and today Luanda remains without a safe and functioning blood bank to serve the crowded hospitals.

*HIV testing and treatment*

Presently very few people are tested for HIV infection in Angola, and the percentage of HIV prevalence in the population is still said to be low. If Angola want to make a serious effort to hold up the propagation of the virus and make use of the possibilities to medicate seropositive individuals, at least pregnant women should be motivated to undergo testing. Independently of the national Programme to Combat HIV/AIDS,the Luanda province has a functioning structure with Health Centres and Hospitals where pregnant women come to antenatal consultations.

*Family planning*

Family planning activities have gone down during the last couple of years. This important component should need more attention, since Angola has openly cultivated a very pro-natalistic policy, but without considering how the extreme poverty affects big families whose children die from preventable or curable diseases and how women die after illegal abortions or in childbirth after having too many children.

*Child health services*

The paediatric emergency 24 hours' wards function well. They consequently apply the IMCI method and are regularly supplied with drug kits. Since Sida's support to CAPEL only functioned during ten years, it is too early to observe any clear effects on the flux of patients to the Paediatric Hospital in Luanda, that is still overcrowded with patients and has difficulties to cope. Things might slightly change for the better with the Paediatric ward at Augusto N'Gangula Hospital and with continued investments in peripheral paediatric wards that are still very few compared to the needs. To respond to the needs through expanding paediatric services at all levels will take time, considering that children <15 years of age constitute around 50% of the population *(MICS, 2003)*.

*Low immunization coverage*

An inconceivable weakness of the MCH system is the low vaccination coverage of children as well as of pregnant women (anti-tetanus). The EPI has been active in Angola since Independence, and results are still very bleak. Routine vaccinations must be the rule, and the broad campaigns the exception, and vaccination services must always be available at Health Centres and paediatric wards. In that way risks are minimized for children to remain without immunization. EPI has recently started to use the new vaccine (Pentavac) which facilitates vaccination, since children get five vaccines in one.

*Sustainability in a longer perspective*

Although we are rather impressed by the development within the MCH sub-sector, it is too early to judge whether the DPSL will be able to continue developing the access to and quality of health services in general and MCH services in particular. A continued positive development will need strong political support so that resources can be guaranteed to the most densely populated province in the country. But strengthened management capacity is also needed to implement the urgently needed reforms.

The final conclusions refer to Sida, and the phasing-out of Swedish support:

*Too short notice, too short phasing-out period*

The Swedish decision – by the Ministry of Foreign Affairs and Sida – to bring the support to MCH in Luanda to an end seems rather improvised and neither well founded, nor well planned. Few people at high posts in Luanda were fully informed, since there was no longer any general cooperation agreement between the governments, only a specific agreement with the MoH. This situation risks undermining the confidence from the Angolan party, since the motives have not been clearly understood and many Angolans mean that the time is ripe to establish cooperation on a solid ground after the country has gained peace and a relative stability, instead of phasing it out.

We believe that the Angolan party, i.e. the DPSL, has succeeded to cope with the change of scenario and has been able to shoulder the responsibility to take back the former projects into the organization. This has happened against the odds, since phasing-out was announced with very short notice and was planned to be finished after only two years. In reality it took even shorter effective time because of the frozen disbursements and delayed signing of the final agreement.

*Was phasing-out a right move?*

Although we have concluded that MCH in Luanda has not collapsed after the withdrawal of the Swedish financial support and technical assistance, we want to raise the question whether it was at all justified to terminate this programme. Several factors indicate that cooperation could have continued, possibly in modified forms and under DPSL's leadership, especially since working conditions have improved after peace was established in 2002 and the basis for cooperation in many ways changed for the better. There is still a lot to do to improve the MCH services, for example in health management and planning. We have not found any traces of a dialogue between the parties or an analysis of pros and contras regarding continued support and/or phasing-out, which makes this decision appear very little objective and facts based.

# 15. Recommendations

## 15.1 Recommendations to Sida

*Phasing-in again*

An earnest recommendation to Sida and the Swedish government is to resume support to MCH in Angola within the scope of the so-called 'selective cooperation' This has nothing to do with cooperation in its conventional forms – funding, equipment, and miscellaneous consultants – and its objectives and goals should be identified and thoroughly analysed by the Angolan party, which today is well aware of the resources on the Swedish side.

In the MCH field Sweden has comparative advantages over other external actors in Angola and MCH is a well-developed area in Sweden. It does not, however, need to be an exclusive Swedish area. There are other actors in maternal health as well as in child health, and dialogue and coordination of resources is needed to avoid a situation from which Angola has been suffering for a long time, i.e. different methods and norms and limited regard to Angolan preferences and knowledge. The Angolan party should take the lead, since a strong Angolan ownership is a condition for any step forward in this direction.

Among possible areas is further training of staff in health management which would benefit not only the MCH area. Sweden has supported the creation of the midwifery profession in Angola, so why not support a modern administrative profession for the health sector? Angola also needs to continue strengthening decentralized obstetric care, since the Luanda model is gradually being replicated in other

provinces. Obstetricians are few – only 51 Angolan in the whole country – which leads us to propose an investment in training of some of the most skilled and experienced midwives to become *técnicos de cirurgia* (nurses with surgical competence) to be able to perform caesarean section in the first place. There is indeed a strong opposition among obstetricians against such an intrusion into their area, so it could be of strategic importance if a Swedish institution (e.g. a hospital run by the county council) could back up such a complementary course. In Angola it could be run by the Course for Specialization of Midwives and in collaboration with those Angolan obstetricians who are already connected to the course as lecturers.

This kind of collaboration could gradually develop into research cooperation in obstetrics and paediatrics, or even social sciences like social anthropology, sociology, etc. from which research input is needed to the MCH sub-sector.

*Phasing-out takes time*

Swedish development cooperation has limited experience of phasing-out and finishing programmes/projects. There are however a few examples that can be studied, e.g. the phasing-out of the Mozambican-Nordic Agricultural Programme (MONAP), which presents some similarities to the broader health support programme in Angola.

One lesson from the MONAP case is that phasing-out takes time. The Nordic decision to phase out the huge support to the agricultural sector was announced five years in advance (1986) by a high level Nordic delegation during a seminar with time for discussion and exchange of ideas. The objective was actually to reorganize the cooperation, so that each of the five Nordic countries could take over the most strategic parts of the programme instead of maintaining the joint Nordic responsibility for the programme.

In the Angolan case, phasing-out seems to have been done by a blow of the axe and surprised Sida's Health Division as well as the Angolan MoH and DPSL. Sida had no well-grounded phasing-out strategy and when, finally, the planning procedure could start in Luanda after several months of delay, it became more directed towards the spending of the agreed budget and less towards an analysis of the post-cooperation situation. This phasing-out method was extremely risky and it could have jeopardized the achievements made during more than ten years' work in the MCH sub-sector. That this did not happen is certainly not due to Sida.

The time horizon is always a crucial factor, but not only for phasing-out *per se*. Agreements and plans must be negotiated and this preparatory process must be allowed to take time. Phasing-out should ideally be based on agreements of let us say three to five years. Phasing-out should be announced even more in advance, or, even better, built in from the beginning of a cooperation partnership.

It is thus strongly recommended that Sida learns the lesson from this case and from earlier cases in development cooperation history. Sida needs to analyse its phasing-out methods to create guidelines for handling phasing-out situations, whether they happen under controlled conditions or in emergency situations.

Since *sustainability after phasing-out* is an underlying aspect of this evaluation, we recommend that Sida uses the possibility to make a continued follow-up of the Angolan MCH case, with one or two evaluations after certain intervals. The result of such a follow-up process could give productive input to Sida's own analysis and learning.

*Self reflection*

The Swedish motive for phasing-out the bilateral cooperation with Angola seems to have been purely political. Even so, the Swedish party should have needed to make some self reflection to analyse the frustrations behind its drastic decision and look back at the almost three decades of bilateral cooperation with Angola. These thirty years were filled by setbacks, and in spite of much good will and effort, the declared goals where not achieved. The Angolan experience was never thoroughly analysed by Sida

(please refer to the evaluation *Healthy support? A study of Sida's support to the Health Sector in Angola 1977–2006)*, but seems nevertheless to have influenced the decision to finally withdraw also from the MCH sub-sector, where, in fact results eventually have been rather positive considering the adverse conditions.

There are, thus, reasons for Sida to analyse its own role in Angola, and such a reflection belongs to any decision of withdrawal from a long cooperation partnership. It should also be brought up for discussion with the respective government so that motives can be understood – and openly questioned – by the other party.

## 15.2 Recommendations to DPSL

Most of the following recommendations to DPSL are, for self-evident reasons, practical and oriented towards the future:

*Information and management*

We have mentioned some few examples of lack of information from the centre to the periphery. To avoid information gaps, and facilitate the management of the new decentralized system, better contacts must be established and relevant documentation elaborated (manuals, regular newsletters, etc.). Responsible staff at DPSL have to control that important information, e.g. on budgets and administrative issues, are passed from the District Health Section to the Health Units.

Recurrent management training will be needed to strengthen the district level, and District Health Sections as well as Health Units need computers and adherent training to be able to perform according to their new responsibilities.

*Human resources*

Health staff with specialized training, e.g. in paediatrics or reproductive health, is now and then moved internally to other areas so that their special competence can no longer be utilized by the MCH programme. It is strongly recommended that such measures be avoided, so that specialized staff continue working in the field where their training and professional experience can make a difference.

*Immunization and health education*

With the extreme pressure on some parts of the health system, e.g. paediatric wards at all levels and the big maternity hospitals, it will take generations before the poor health system in Luanda will be able to respond to the needs of the citizens. More investment in prevention will therefore be needed as an immediate measure.

It is since long well-known that the EPI does not function well enough to reach all children and pregnant women. Even though EPI has started using the new and more practical vaccine (Pentavac/ Pentavalente) it is important that DPSL not only intensifies follow-up of the immunization programme but also elaborates new methods for reaching out to the communities.

DPSL should invest more in health education with mobile teams and informal and attractive communication techniques such as theatre, music, etc., and not only continue using the classical posters and booklets that might no longer appeal to a population that is getting used to TV ads and soap operas. Health education by health workers and "agents" *(agentes sanitários)* goes on at Health Centres and Posts, but the monophonic lecturing should be changed for more participatory methods where people can voice their own health worries. It goes without saying that other languages than Portuguese have to be used according to the audiences. Collaboration should be established with civil society organizations to reach families/households in their local communities. Direct contact will produce better results than posters or radio programmes, since it also gives a possibility for feedback and to check whether the audience has got the message right.

*Illegal fees*

The new budget system is a powerful, although still insufficient, instrument to put an end to *gasosas*, and other illegal practices, since these can no longer be motivated by the lack of drugs and disposables at Health Centres.

Economic obstacles, such as *gasosas* and selling of essential drugs, gloves and other disposables, function as effective barriers for the poor to use available services and must thus be taken seriously by DPSL. It is not enough to create norms and rules to be followed; a system of sanctions must be established, enforced and monitored and not only staff, but also users should be informed about it. It must be broadly publicized that antenatal care and safe delivery, as well as health care for children, are rights which are free of charge and that users should not accept to pay *gasosas* at any level or to buy gloves, syringes, etc. from health staff.

*Control of stocks*

The distribution and control of life-saving drugs, such as oxytocin, antibiotics, hemacel, diazepam, etc., must be analysed by the MCH section of DPSL, since it is evident that these essential drugs are relatively often lacking in delivery rooms or exist in too limited quantity. This seems, partly, to be an information problem since some Health Centre staff allege not understanding why supplies do not arrive, and only know that CAOL and CAPEL have ceased existing.

Regular control of stocks of disposables is also needed, to avoid shortage or to reallocate disposables (or drugs) between Health Units.

*Urgent needs for safe deliveries*

There is still no *blood bank* to serve the Hospitals in Luanda. This is one of the most serious matters that must be analysed and solved urgently by DPSL in collaboration with the MoH and the National Blood Centre *(Centro Nacional de Sangue)*.

Since haemorrhage during delivery is one of the most frequent and serious pathologies, all Hospitals must have a permanent supply of blood since transport of blood from a central blood bank is not realistic considering the chaotic traffic situation in and around Luanda.

Cheap *vacuum extractors* should be imported and distributed to Health Centres and Hospitals, to try to bring down surgery, which has always certain risks for the patient, while the vacuum extractor is inoffensive when used in the right way. Midwives and nurses need to be (re)trained in using the vacuum extractor, since this instrument has fallen into disuse while the number of caesarean sections is increasing dramatically and has come to constitute a clear misuse of scarce hospital human and material resources, let alone the risk for the patient.

The *partogram* is an important method to control the delivery process, but we have understood that few midwives know how to use the partogram. It is thus recommended that strengthened supervision of midwives'/nurses' use of the partogram be undertaken combined with (re)training of midwives and nurses.

Finally, *ambulances* must be kept in order and the *radio communication* system re-established to make the referral system function. With radio communication midwives can contact district hospitals to know if they have blood, and to make them prepare for the arrival of a patient. Ambulances and radio communication are saving lives.

*Maternal death audits*

It is strongly recommended to implement regular maternal death audits at the all maternity hospitals (including Lucrécia Paím Hospital). These audits should be led by a senior and respected Angolan

obstetrician who should also be instrumental in developing strategies for the Luanda province to combat the high intrahospital maternal mortality.

*Abortion*

The complex issue of abortion should be addressed and somehow included in reproductive health. Illegal abortions still contribute to maternal deaths, even though the potent abortifacient drug misoprostol (Cytotec©) is openly sold in Luanda. Cytotec© does not normally kill a pregnant woman, but other methods do and hospitals daily receive young women who have tried to make an abortion with pills or with other, more dangerous, methods. There is an urgent need to develop a strategy to handle abortion as a reproductive health problem. Family planning services need strengthening, sex education is needed in schools and, finally, a liberalized attitude towards abortion when there is a need for it.

*Community work to promote safe motherhood*

During quite some time, UNICEF and CAOL were identifying and training so called traditional midwives (Traditional Birth Attendants/TBA). The training was short and very elementary, mainly aiming at teaching how to identify obstetric risk cases and to improve hygienic conditions during domestic deliveries. Each TBA received a kit from UNICEF containing medical alcohol, a pair of scissors, dressing materials, etc.

From a certain point of time, these TBA courses stopped and today the MCH programme has no organized contacts with the TBAs in the province. Some say TBAs do not at all exist, obstetricians say that, if they exist, they have certainly no role in reducing maternal mortality, and in any case UNICEF has no interest in promoting this group. In spite of this, there is still a National TBA programme!

In 1999, the evaluators of the Maternal Health programme wrote:

> Before estimating impact of the programme on maternal health in the Luanda province, more information is urgently needed about the characteristics and outcomes of deliveries outside the health care institutions.
>
> Home delivery assistance has never been the focus of the programme. No systematic collaboration between peripheral health posts/maternity clinics and TBAs exists, and there is no current data available on the number of home deliveries or deliveries attended by TBAs. Thus, the vast majority of deliveries in the province take place under circumstances little known to the programme or the professional health providers. Consequently, also the outcome of these deliveries is unknown *(Andersson-Brolin & Wessel, 1999)*.

This recommendation has not been followed, probably because Swedish/international experts do not think highly of TBAs and also because of CAOL's/DPSL's work load to make the delivery wards function with a minimum of safety and quality.

Since these thousands of women who do not come to the delivery wards are usually assisted by another woman during childbirth, be she classified as TBA or not, time has come to reach out to the TBAs and bring them into the system. CEP is now and then inviting them to the course, to learn from them and to give them some basic lessons. But this seems to be the only link today, except for the new District Committees for the Prevention of Maternal Mortality where TBAs are supposed to have a seat.

It is thus recommended that DPSL's MCH programme makes an inventory of active TBAs in the province and starts a dialogue to identify their capacity as well as their training needs. They can be an important link between the community and the health services. The TBAs can equally be helpful with information about the characteristics and outcomes of home deliveries and, above all, about women's preferences.

*HIV situation*

Testing and counselling need to be strengthened so that more women and their partners can be tested through the maternal health structures. If testing shall have a really voluntary character, the first step must be counselling through which patients can be well informed without being stigmatized and agree to being tested. The health services, must also, consequently be ready to administer ARV treatment if needed, at least initially until patients can be transferred to a well functioning treatment programme.

Treatment of HIV infected women, men and children must be a human right and all citizens need to understand this. This is the only attitude which can help bringing down the HIV prevalence in a long-term perspective.

Mothers must have full support from the Health Centres where they receive treatment, so that they feel secure about how to feed their infant to avoid transmitting the infection. It is known among health staff that women cannot always stick to bottle-feeding their babies because of stigma and tradition, and especially young infected mothers will need strong human support from very professional health staff.

Safe-sex-messages must be a top issue at Health Units that work with family planning and sex education for adolescents. The health system cannot work with blinkers, in a situation where sexual behaviour is rapidly changing among urban youth, prostitution is growing dramatically and sex education in schools is very poor or non-existent.

*Family planning*

Also family planning should be a human right, based on a humane attitude. This is an area where tactful pedagogical efforts are needed to make men and women understand that family planning is for their own good and not a routine top-down message. Since numbers of FP visits are going down, the issue has to be thoroughly analysed by DPSL to find methods of communicating the message so that new groups can be reached. So called family planning must be reformulated into reproductive health and be seen as seen as one of several measures to ensure greater maternal survival – multipregnancy mothers represent a high percentage of the pregnancies with high obstetric risk. Their proportion of the number of unsafe abortions is unknown.

*Maintenance of equipment and infrastructure*

Since the lack of maintenance and repair of ambulances, other vehicles and all kinds of medical equipment is one of the biggest problems identified by the Health Units, and in reality one of the causes contributing to the lamentable numbers of maternal and child deaths, DPSL has to take a real firm grasp of the situation. Today there are only two alternatives: Either the DPSL sees to it that its maintenance team starts functioning with a group of professionally competent mechanics that can circulate regularly among the Centres and Hospitals that come under DPSL's responsibility, or each Centre and Hospital must have a rather generous budget to solve the maintenance problem with the help of local garages or other firms.

Independently of the option, it is necessary to organize elementary training for staff at the Health Units in maintenance planning, small repairs, etc., to facilitate for the Centres to handle their equipment in the best possible way and to plan the use of the monthly budgets.

*Better statistics*

For all purposes – theoretical and practical – the quality of the statistics of the health system needs urgent improvement. Some efforts have been made by the InDevelop staff through the years, but we have no information about the extent of training of staff at Health Units in the collection and analysis of data. Staff at the Department for Studies and Planning confirm the deficient quality of the data that arrive at DPSL from the field, but until now it has not been possible to undertake training of staff with

responsibility of collect and process data at the Health Units. Routines seem not to be established so that statistics arrive at DPSL on time (in the draft of the annual report some important Health Units were simply missing) and with the present shortage of staff DPSL's capacity to go out to give hands-on support is rather limited.

It will not be possible for DPSL to follow budget utilization or even to make the simplest analysis of the productivity of the health system based on a cost/case/treatment estimate. The quality of provincial statistics, thus, goes together with the budget reform. This should motivate the recruitment of more statisticians to the Planning department at DPSL and, in addition, a well planned staff training at the Health Unit, e.g. organized in collaboration with the INE.

Statistical reports are not only a working tool for the central level (DPSL) but also for the Health Units. It serves as feedback and information about trends of service delivery, etc. within the system. Although the DPSL report for 2006 is incomplete and full of question marks regarding the statistical contents, it is an ambitious and partly quite interesting publication. In the future, this kind of reports should be edited in a way to make it accessible for a broader audience and not only for the top decision makers. It should be widely spread to health staff, NGOs and other civil society groups, the media, etc.
The public administration has an obligation towards the citizens to supply reliable information regarding the health situation and service delivery in the province and to answer questions from the grassroots.

# Appendix 1 Terms of Reference

… for the Evaluation of Sida's Health support to Angola

## 1. Background

Sweden has been involved in program support to the health sector in Angola since 1983, and during most of this period the country has been in a situation of varying degrees of civil war. The nature of the support has changed over time. During 1983 to 1985 an extensive program was prepared that started in 1986 and continued until the civil war broke out after the elections in 1992. The support during this period included support to infectious diseases programs like malaria, tuberculosis and sleeping sickness as well as support to essential drugs, nurse training and public health planning.

From 1993, the focus has been narrowed down to support to maternal and child health in the Luanda Province, support to a midwifery school and to the national immunisation programme. The main rationale behind the programme during this phase has been humanitarian, and hence its focus has been on service delivery rather than more long-term objectives such as health systems development.

In line with the present Country Strategy, the health programme will come to an end 31 March 2006. The main part of the bilateral country programme will be phased out during 2006. From 2007 and onwards, development co-operation will be mainly in the form of regional and multilateral channels.

After the end of Swedish Health development cooperation, two studies will be commissioned:
One study will focus on the entire experience of Angolan-Swedish health cooperation and provide a general overview of its advances and setbacks. A second one will consist of an evaluation of the phasing-out of the health cooperation; the following terms of reference relate to this latter project.

## 2. Purpose and Scope of the Evaluation

The purpose of this evaluation is to evaluate the phase-out period June 2004 to March 2006. In particular, the evaluation shall focus on the extent to which the process of phasing out has had an effect on the sustainability of the health components supported by Sida

## 3. Stakeholder Analysis

For material, the evaluation shall take into account material and interview data from both the Swedish and the Angolan side. The analysis shall focus on the actions of both sides, and shall also attempt to produce conclusions that may be relevant to them both. Additionally, the evaluation shall take into account the views of other international cooperation agencies present in Angola.

## 4. The Assignment

### 4.1 Issues to be analysed

i. What were the goals for each side (Swedish and Angolan) with regard to the process of phasing out? How were they to be achieved? In this regard, the program theory of the exit process shall be outlined along with assumptions that it has entailed.

ii. What resources/activities have been undertaken by each side in order to ensure a successful phasing out of the Swedish support?

iii. To what extent have the goals in the exit process been attained, and what has accounted for their attainment? What other effects, possibly unforeseen, can be detected in the process? What could

have been done better in the phasing out process? What recommendations can be drawn up for the Angolan and Swedish side with regard to similar processes in the future?

iv. Overall, what have been the effects of the phasing out of Swedish cooperation with Angola on the sustainability of the health components supported by Sweden?

v. How has the phasing-out of the project affected the beneficiaries and the service delivery?

## 5. Evaluation Questions

In addition to what has been outlined above, the following specific questions shall be addressed in the evaluation:

1. Has capacity development and institutional development been successfully implemented in order to make the programs sustainable, especially related to service provision, supervision, planning and monitoring, drug supply, financial management and maintenance of infrastructure, equipment and vehicles?
2. Have sufficient resources been created/available to make the programme sustainable after Sida's departure?
3. How realistic were the objectives for the phasing out period?
4. What were the experiences of applying the "staircase model" of phasing- out, outlined in the project documents?
5. To what extent was sustainability dependent on the process of phasing-out?
6. What were the effects on the provincial and municipal health services in Luanda province, of the Swedish phasing out? Could anything have been done to mitigate those effects further? How did the structure of the programme change after the phasing out of Swedish support? Is there a difference in the service delivery output compared during the phasing out period and after the phasing out period?
7. Will sufficient resources be allocated to the programme after the phasing-out period (domestic resources and/or external aid?) to ensure continuity and sustainability of components?
8. How has the extent of the activities within the programme been affected by the phasing out of the Swedish support?

## 6. Methodology, Evaluation Team and Time Schedule

After preparation and collection of relevant documents from Sida, the main part of the evaluation will be conducted in situ in Angola. This includes interviews and surveys involving present and former actors in the programme, health staff and health workers representing all components of the programme, representatives from other donor agencies and NGOs, as well as other persons deemed important. The list of persons to be interviewed shall be discussed with local partners.

### 6.1 Evaluation Team

The consultancy team shall possess expertise in public health with a special knowledge of obstetrics, midwifery and child health, as well of management issues. All members of the team should be Portuguese speaking.

At least one consultant shall be an Angolan national.

None of the consultants shall have been directly involved in the programme during the phase-out period.

### 6.2 Time Schedule

The assignment can commence as soon as the contract has been signed. Work shall be performed in three stages.

A first phase, will take place prior to the complete phasing out of the Swedish

Health cooperation, i.e., in March 2006.

After 6 months, a second phase shall take place.

After 12 months, a third and last phase shall take place.

The total number of consultancy weeks is expected to be between 10–15 (four weeks for first visit, two for the second one, four for the last one; plus reporting). The weeks can be divided between several consultants, and Sida welcomes suggestions as to how they should be allocated.

The proposal shall include a division of the number of weeks in work in Sweden and in Angola that the Consultant expects to use for the assignment.

Before leaving Angola after the third visit, the evaluation team shall present findings for comments and discussions in a meeting with the Ministry of Health if the latter wish so.

### 6.3 Sources

At a minimum, the following sources shall be considered:

– The programme co-ordinators and other personnel.

– Representatives from the Angolan health authorities.

– Representatives from local and national NGOs present in the sector of health.

– Present and former health staff and health workers

– Project documents

– Operational plans

– Quarterly, semi-annual and annual reports

– Minutes from quarterly and annual meetings

– Other evaluations, reports and studies

## 7. Reporting

Prior to the first visit to Angola, an oral inception report shall be presented to Sida at a meeting in Stockholm. The presentation shall discuss detailed evaluation questions, indicators and proposed data. The rest of the assignment is conditioned in its approval by Sida.

After each of the first two visits, a brief field report shall be presented to Sida, and subject to discussion between Sida and the consultants. This report shall not exceed ten pages.

The final evaluation report shall be written in English and should not exceed 20–30 pages, excluding annexes. The Embassy will subsequently have the report translated to Portuguese. Format and outline of the report shall follow the guidelines in *Sida Evaluation Report – a Standardised Format* (pls see Annex 1). The draft report shall be submitted to Sida electronically and in three hard copies (air/surface mailed or delivered) no later after three weeks after the third phase of the assignment. Within three weeks of receiving Sida's comments on the draft report, a final version shall be submitted to Sida, again electronically and in three hard copies. The evaluation report must be presented in a way that enables publication without further editing, and have been professionally proof-read. Subject to Decision by Sida, the report will be published in the series *Sida Evaluations.*

The evaluation assignment includes the completion of *Sida Evaluations Data Work Sheet* (Annex 2), including an *Evaluation Abstract* (final section, G) as defined and required by DAC. The completed data worksheet shall be submitted to Sida along with the final version of the report. Failing a completed Data Worksheet, the report cannot be processed.

# Appendix 2 Consulted References

### Consulted archives

Sida headquarters, Stockholm

Swedish Embassy, Luanda

InDevelop, Luanda

### Evaluations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# Appendix 3 Interviewed Persons

## In Luanda

### Ministry of Health

Dr. José Vieira Dias Van-Dunem, Vice Minister of Health, Ministry of Health

Dr. Constâncio João, Deputy Director, Essential Drugs Programme

Dr. Adelaide de Carvalho, National Director for Public Health, former Project Coordinator CAOL

### Provincial Directorate for Health in Luanda (DPSL)

Dr. Vita Vemba, Director, former Coordinator of the Institutional Support Project

Dr. Isilda Neves, Director Primary Health Care, former Project Coordinator CAPEL

Dr. Isabel Massocolo, Head of Section Mother and Child Health, former Project Coordinator CAOL

Dr. Catarina Oatanha,
Coordinator of the Immunisation Programme and the Programme for Health Promotion

Dr. Alexandra Fernandes, Coordinator Endemic Diseases

Dr. Paula Barbeiro, Epidemiologist

Dr. Marta Jaime Chigango, Head of Department Human Resources, DPSL

Mrs. Ana Isabel Angelina, Nurse, Tutor CAPEL

Mrs. Teresia Francisco, Midwife, Tutor CAOL

Mrs. Conceição Gaspari, Midwife, Tutor CAOL

Mrs. Rosa Maria, Midwife, CAOL

Mrs. Maria Gonçalves, Head of Finance Section

Mr. Zacarias António, Statistician

Mr. José Mobiala, Head of Transport Section

Dr. Tando Fulevo, Director Logistics

Mr. Silva, Motor Mechanic, Maintenance Team

Mr. Dionísio, Motor Mechanic, Maintenance Team

Mr. Manuel, Electrician, Maintenance Team

### National and General Hospitals

Dr. Abreu Pecamena Tondesso, Director General, Lucrécia Paím Hospital

Dr. Luís Bernardino, Director General, Paediatric Hospital David Bernardino

Dr. Rosa Bessa, Director General, Augusto N'Gangula Hospital

Dr. Maria Fatima Jorge, Obstetrician, Clinical Director, Augusto N'Gangula Hospital

Dr. Rosa Maiato, Obstetrician, Augusto N'Gangula Hospital, Luanda

Dr. Jerzy Niekowal, Obstetrician, Augusto N'Gangula Hospital

Dr. Eurica Sebastião, Clinic Superintendent, Camama General Hospital

Dr. Aurora, Cândido, Obstetrician, Camama General Hospital

### Cajueiros Hospital, Kazenga District

Dr. Makutuala Maku, Administrative Director

Mrs. Anita José, Specialized Midwife and Administrative Head of Section

Mrs. Paula Cristina, Midwife, Team Leader
Mrs. Cecília Damais, Nurse/Midwife
Mrs. Francisca Trindade, Nurse
Mrs. Maria Semedo, Nurse/Midwife
Mrs. Maria Alexandre, Midwife
Mrs. Lizete Pinheiro, Hospital supervisor
Mrs. Joana Quiosa, Midwife
Mrs. Sebastiana António, Hospital attendant
Dr. Claudina Francisca, Obstetrician
Dr. José Marcos, Paediatrician
Mrs. Domingas Valente, Nurse
Mrs. Vanda Maria, Midwife
Mr. Faustino Rodrigues, Nurse
Mrs. Júlia Cassinda, Nurse, Responsible for Chirurgical Instruments

**Kilamba Kiaxi Hospital, Kilamba Kiaxi District**
Dr. Judite A. Venâncio, Clinical Responsible for the Hospital
Mrs. Felícia Júlio, Nurse
Mrs. Evalina Politano, Nurse
Mrs. Luisa Edgarda, Midwife, Responsible for Delivery Room
Mr. Seke B. Eduardo, Supervisor
Dr. João Luz, Obstetrician, Clinic Superintendent
Mrs. Maria de Lourdes, Midwife
Mrs. Carlota Francisco, Midwife, Team Leader
Mrs. Eva Alexandre, Midwife
Mrs. Julieta Faustino, Paediatric Nurse, Emergency Ward
Mr. Pedro António Quiala, Paediatric Nurse, Emergency Ward
Mr. José Adriano, Statistician

**Hoji Ya Henda Health Centre, Kazenga District**
Mr. Domingo Álvaro, Administrative Director
Mrs. Marcelina Daniel Gonçalves, Midwife
Mrs. Isabel Francisco Ornelas, Midwife
Mrs. Vitória Nawakemba, Midwife
Mrs. Aida Maria Gomes, Midwife
Mrs. Maria Paulina Nyama, Midwife
Mrs. Rita Francisco Júlio, Child Care Nurse
Dr. Agostinho, Paediatrician
Mr. Capitão António, Nutritionist
Mrs. Vitória Kissanga Ernesto, EPI Nurse
Mrs. Rita Batista Agostinho, EPI Nurse
Mrs. Lemba José António, EPI Nurse
Mr. Francisco de Assunção Veiga Mateus, EPI Nurse

Mrs. Feliciana Isabel Paulo, Midwife, Antenatal Care

Mr. Agostinho Javier, Nurse, Medical Student

**Asa Branca Health Centre, Kazenga District**

Mr. Filipe Bala, Administrative Director

Mr. Vasconcelos Celestino Manuel, Paediatric Nurse, Emergency Ward

Mr. Guilherme Neto, Paediatric Nurse

Mr. Domingos Gonçalves Tomás, Paediatric Nurse

Mr. Evaristo Artur Casule, Head of Administrative Services

Mrs. Tita da Cunha, Assistant Head of Delivery Room

Mrs. Isabel Mulaza, Nurse, Antenatal Care

Mrs. Suzana Garcia, Nurse, Antenatal Care

**Ilha de Luanda Health Centre, Ingombota District**

Mr. António Manuel, Administrative Director

Mr. Paiva Alexandre, Superintendent

Mrs. Tomásia da Graça Paulo Vita, Midwife

Mrs. Rosa Alfredo, Midwife

Mrs. Antónia Gomes, Nurse, Youth Counselling Service

Mrs. Noela Guimarães, Nurse, Youth Counselling Service

Mrs. Ilidia Benedito, Nurse, Youth Counselling Service

Mrs. Joaquina da Paixão, Responsible Pharmacy

Mrs. Teresa Panguiceny, Nurse, Head of Paediatric Ward

Mrs. Paulina Nguinamau, Midwife

Mrs. Maria da Conceição Tomás, Midwife, Team Leader

Ms. Maria da Conceição Barros, Trainee, Medical Student

Ms. Genuína Lopes, Trainee, Medical Student

Ms. Maria Ventura, Trainee, Medical Student

**Terra Nova Health Centre, Rangel District**

Mr. José Gonçalo Sebastião, Administrative Director

Mrs. Isabel Pedro, Midwife, Team Leader

Mr. José Francisco Diogo, Paediatric Nurse

Mr. Antonio João, Nurse, Team Leader, Paediatric Ward

Mr. José Gonçalo Tozé, Nurse, Emergency Ward

**Ana Paula Health Centre, Viana District**

Dr. Ana Generosa Hungulo, Director

Mrs. Teresa Belchior, Midwife, Responsible for Delivery room,

Mrs. Ana Cristina Romão, Midwife

Mrs. Celina, Nurse

**Samba Health Centre, Samba District**

Mrs. Laura André, Midwife, Team Leader

Mrs. Ana Basti, Specialized Midwife, Team Leader

Mrs. Teresia Maria da Costa, Midwife, Family Planning

Mrs. Maria Afonso, Midwife, Team Leader Antenatal Clinic

Dr. Juliana Casinto, Paediatrican

Mr. João Gomes, Administrative Director

### Course for Specialization of Midwives (CEP), Luanda

Dr. Engrácia de Freitas, Coordinator

Mrs. Maria da Conceição Barros do Rosário, Midwife, Manager

Mrs. Ana Chilepa, Midwife, Teacher

Mrs. Domingas Beatriz Borba, Trained Midwife, Teacher

### Others

Prof. Paulo Campos, Obstetrician,
Faculty of Medicine, Universidade Agostinho Neto; former Coordinator CAOL

Mr. Tom Abrahamsson, Programme Officer Health/Economist, Embassy of Sweden in Luanda

Ambassador Anders Hagelberg, Embassy of Sweden in Luanda

Dr. Dario Pontes Regis, Consultant, InDevelop, Luanda

Dr. Raúl Feio, Programme Officer, Delegation of the European Commission, Luanda

### In Caxito, Bengo Province

Dr. António Moyo, Head of Department of Public Health, Bengo Provincial Hospital

Dr. Albertina Menezes, Head of Department of Obstetrics and Gynaecology,
Bengo Provincial Hospital

Dr. M'bala Cussumo, Director, Provincial Directorate for Health in Bengo

Dr. António Martins, Director, Bengo Provincial Hospital

Mrs. Sofia Simão Rodrigues, Head Nurse, Pediatric Department, Bengo Provincial Hospital

Mr. Coxe André, Nutritionist Nurse, Pediatric Department, Bengo Provincial Hospital

Mrs. Madalena Amaral, Nurse, Pediatric Department, Bengo Provincial Hospital

Mrs. Catarina Catí, Nurse, Caxito Health Centre, Bengo Province

## In Sweden

Dr. Anders Molin, Head of Health Division, Sida

Mrs. Ewa Nunes Sörenson, Programme Officer, Health Division, Sida

Dr. Britta Nordström, Programme Officer, Health Division, Sida

Mrs. Susanne Spetz, Programme Officer, Department for Africa, Sida

Mr. Roland Svensson, former Sida Programme Officer at Embassy of Sweden, Luanda

Mr. Bernt Andersson, former Adviser Ministry of Health,
former Programme Officer and Acting Head of Health Division, Sida

Mr. Kent Jönsson, former Technical Adviser, InDevelop Luanda

Mr. Gert-Agne Gustavsson, Maintenance Specialist, Short-time Consultant, InDevelop

Mr. Torgny Quick, Maintenance Specialist, Short-time Consultant, InDevelop

Dr. Anna-Karin Karlsson, General Practitioner, former Programme Manager, InDevelop

Dr. Staffan Bergström, Obstetrician, ICHAR, Consultant InDevelop

Dr. Staffan Salmonsson, General Practitioner, Consultant IPM

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