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Case Study 2: Review of Health Service Delivery In Angola

This paper forms part of the 2004 DFID report on Service Delivery in Difficult Environments, undertaken by the Health Systems Resource Centre

Suzanne Fustukian

DFID Health Systems Resource Centre
5-23 Old Street
London EC1V 9HL
Tel: +44 (0) 20 7251 9555
Fax: +44 (0) 20 7251 9552
www.healthsystemsrc.org

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DFID Health Systems Resource Centre
5-23 Old Street
London EC1V 9HL
Tel: +44 (0) 20 7251 9555
Fax: +44 (0) 20 7251 9552
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1 COUNTRY CONTEXT

Angola, with a population of 13.6 million[1], has faced almost forty years of war from 1961, when a war for independence was fought against the colonial Portuguese state, to 2002, when a peace settlement was signed between the two opposing parties; the government (led by the MPLA) and UNITA. Despite two prior attempts at negotiated peace settlements between the government and UNITA, first in 1991 (Bicesse Accord) and then in 1994 (Lusaka Protocol), it was not until the outright victory of the government forces in April 2002, upon the death of the UNITA leader, Jonas Savimbi, that a sustained peace settlement was possible. This has left the ruling government, the MPLA, in uncontested control since 2002[2].

1.1 Classifying Angola as a difficult environment

'Difficult environments' is a relational concept based on operational and outcome oriented issues, focusing on whether 'normal lending instruments can be used successfully' by donors[3], particularly where 'partner governments do not have credible commitments to effective policies and their implementation'[4]. Furthermore, 'difficult environments' are characterised by high levels of insecurity, significant human rights infringements, weak state institutions, and low levels of transparency and accountability to its own citizens[5]. Angola manifests all of these characteristics and has been a 'difficult environment' since its independence from Portugal in 1975. Following independence from Portugal, with the subsequent migration of most of the skilled Portuguese professionals[6], the country became a proxy Cold War struggle between the Soviet Union and Cuba and the USA and Africa through their support for the MPLA and UNITA, respectively. Both of these events severely curtailed its capability to implement its radical social programme. Since then, defence spending by the MPLA government had been sustained at very high levels throughout much of this period, with limited support for the social sectors[7]. This, linked with low managerial capacity, limited territorial control (particularly of areas under UNITA control) and high levels of insecurity, has led to the virtual collapse of the state social sector throughout the country[8].

Up to the signing of the Bicesse Accord in 1991, external involvement by western development agencies (donors and NGOs) in Angola's social sectors was extremely limited[9]. Reasons suggested for this lack of engagement include the lack of commitment by the government to these sectors, given the rich mineral resources available, a perception that continues to hinder donor engagement in 2004. Donors were also reluctant to provide aid that would, inadvertently, allow the government to re-allocate funds from the social sectors to the war[10]. Despite significant revenues from highly lucrative extractive industries – oil (coast/offshore) and diamonds (north-east), neither the Government nor UNITA invested significantly in state administration or development in the areas under their control, using the revenues instead to pay for

[1] UN 2003 estimate in UNDP, 2004
[2] ICG, 2003b
[3] World Bank, 2002
[4] OECD, 2001
[5] OECD, 2001
[6] Brittain, 1998
[7] Tvedten, 1997
[8] Pavignani and Colombo, 2001
[9] Cain et.al.2002
[10] Pavignani and Colombo, 2001

their war machines, for personal gain and to secure a network based on patronage[11] [12]. External assistance has been slowed by donors' concerns over the lack of commitment and responsiveness of the Government to the country's recovery needs. The Norwegian Refugee Council highlights that the lack of transparency and accountability over its oil revenues has clouded the Government's record and inhibits the donors from committing resources:

> "Angola has one of the biggest oil reserves in the world and the foreign owned offshore oil industry accounts for over 90 per cent of state revenue. The country is also the world's fourth largest diamond producer. Allegations of corruption and embezzlement are rife, in spite of the government's clear and unambiguous public commitment to account for all its oil revenues (Global Witness, 20 June 2003). According to an IMF report, about US$1 billion could not be accounted for in 2002 – approximately one third of the entire state revenue (Angola Peace Monitor 14 Jan 2004)" [13].

At the British Angola Forum in November 2003, the donor consensus was that "*short-term emergency aid to Angola will continue"*[14]. Three government bilateral programmes, the UK, Netherlands and Norway, indicated that they would only give limited help outside the scope of humanitarian aid. Finally, the 2002 UN Common Country Assessment [15], also underlines that "*the absence of a basic policy framework for good governance, sound economic management and poverty reduction measures has led most donors to classify Angola in the 'fragile partnership' category"*[16].

1.2 Historical phases

Between 1975-1991, the period of the proxy cold war, an alternative source of finance and technical support came from the Soviet Union and Cuba. Pavignani and Colombo[17] highlight that "*the Cuban model of health care, very influential at the time, accentuated the over-reliance on doctors that characterised MoH plans.*" However, very little is published about this period or about the influence on the Angolan government of the Soviet or Cuban models of service provision. Given the ongoing security concerns, government funding directed to the social sector has "*targeted mainly city dwellers in Luanda and other cities, and has been affected by regressive patterns of distribution and frequent leakages"*[18]. Since this period, the concentration has been largely on tertiary level health care, with subsequent disregard for the wider health (mainly rural) network and its consequences for population health[19].

Following the Bicesse Accords in 1991 and the Lusaka Protocol in 1994, donors became more willing to engage with the government. WHO reports that "*over the decade, Angola received a total of US$3.6 billion, 59% dispersed by bilateral donors and 41% by multilateral donors*"[20] Support for the reconstruction of government

[11] ICG, 2003a
[12] Jenkins et.al., 2002
[13] Norwegian Refugee Council *reliefweb March 2004*
[14] Angola Peace Monitor, December 2003
[15] UN 2002
[16] UN 2002: 87
[17] Pavignani and Colombo, 2001
[18] Sogge, 1994 in Pavignani and Colombo, 2001
[19] Pavignani and Colombo, 2001
[20] WHO, 2003

infrastructure and institutions was channelled mainly through the UN and INGOs; direct service delivery and humanitarian assistance by INGOs were also supported[2122]. The World Bank initiated a Social Action Fund in 1994 in collaboration with the Government but targeted to community designed and managed projects[23].

The renewed outbreak of war between the Angolan Government and UNITA at the end of 1998 resulted in the withdrawal of most donor programmes from the country except for those funding humanitarian assistance in the more secure areas. The return to war on both occasions, in 1992, and again in 1998, found the international community unprepared. Most had shifted their programming in Angola from humanitarian assistance to reconstruction and longer-term development programming; as a result, staff experienced in relief were involved in emergencies elsewhere[24].

Up to 80 per cent of the country became inaccessible to humanitarian agencies between the end of 1998 and early 2002 due to heavy fighting and the inaccessibility of 'grey' zones controlled by the government or UNITA. Seven provinces were heavily mined preventing access and movement[25]; many landmine victims were women and children searching for food and wood. Bridges and roads to many of these same provinces were also destroyed. The populations trapped in these areas had high crude death rates closely linked with high rates of severe malnutrition[26]. More than four million people (31% of the population) were internally displaced[27] and more than 60 per cent lived below the poverty line. At the end of the war, less than 30 per cent of the population had access to adequate health care; the national indicators for health were surpassed only by Sierra Leone, and were much worse when geographically disaggregated. The table below provides some current estimates of national indicators:

National indicators	
Life expectancy	40.2(1)
Population w/o access to water source	62% (1)
IMR	150/1000 (3)
U5MR	250/1000 (3)
MMR	1850/100,000 (2)
% of births attended by skilled health attendant	45% (3)
DPT immunisation coverage	34% (3)
Measles immunisation coverage	53% (3)
Polio immunisation coverage	63% (3)
TB immunisation coverage	69% (3)
% of under-fives ill with fever	

[21] Key et.al., 1996
[22] Pavignani and Colombo, 2001
[23] Adauta de Sousa et.al. 2001
[24] Pavignani and Colombo, 2001
[25] UN OCHA, 2002
[26] MSF, 2002
[27] HRW, 2002

who received anti-malarial drugs	61% (3)

Data from 1) UNDP. 2003.
2) UN. 2002. Common Country Assessment
3) Republic of Angola. 2003

2 ACTORS AND APPROACHES IN SERVICE DELIVERY

2.1 Government

During the years of war, neither side were particularly concerned to build up the social sectors in the areas outside the main hostilities; Sogge[28] reports that access to health services in 1990 had "*almost certainly declined*" from the 30 per cent who were estimated to have access in 1980. This is mirrored in the estimated decline from 6.3% in 1988 to 3.4% in 1996-7 of the government's budget allocated to health, of which actual expenditure was often half[29]. A review mission from the UK ODA[30] in 1996 noted that budget allocations to the social sectors were extremely limited and there was "*minimal political commitment to health*." Between 1997-2001, government expenditure on health averaged 3.3% compared with a SADC average of 7.2%; of this more than half was allocated to secondary and tertiary levels[31]. By this stage, up to 65% of the health facilities outside the capital had been destroyed, while the majority of senior and middle level governmental health staff were based in Luanda.

Assistance to the government during the 1990s

During the two lulls in the conflict during the 1990s, several major donor projects were directed to strengthening the public health sector[32]:

- Health Sector Project of the World Bank focused on financial management, health financing and developing a national health plan;
- Post-Emergency Health Project, funded by the EU, supported advisors to the Ministry of Health on health policy
- Health Transition Project funded by the UK ODA, which supported WHO and INGOs to advise and support capacity building the government system.

The HTP project made a determined effort to move away from emergency interventions to support institutional strengthening and strategic support of the country's three administrative levels: central, provincial and municipal. Support to the government, however, was channelled through WHO and INGOs, rather than directly.

Health Transition Project 1995-1998

The Health Transition Project (HTP), funded by the UK Overseas Development Administration (ODA), was an innovative multi-agency partnership that began in 1995. The ODA suggested the merging three emergency proposals from different agencies in order to create a more coherent approach to support the rehabilitation of the national health service. It was designed to operate at three levels, with technical assistance and direct service provision supplied by WHO and two NGOs, Save the Children UK (SCUK) and CARE:

1) At the central MoH, WHO assisted with the development of health policy and planning

[28] Sogge, 1992
[29] Hardiman et.al. 1997
[30] Key et.al 1996
[31] WHO, 2003
[32] Key et.al 1996

2) At the provincial level, technical assistance was provided to provincial health delegations in Huambo, Benguela, and Bie provinces to develop health management systems (WHO, SCUK, and Care)
3) At the municipal level in the three provinces, government health centres were to be rehabilitated to deliver PHC, MCH and family spacing services (SCUK and CARE).

(Key et.al. 1996)

Small but significant steps were made in building the capacity of the provincial and municipal health delegations, but limited progress was possible at central level for political reasons. The 1996 review mission notes that "*government ownership of reform*" was limited[33]. Another consultant noted that, while HTP had focused on PHC, *"government resources are currently concentrated on secondary and tertiary levels"*[34].

WHO made limited progress in assisting the central MOH, in part due to the problems just mentioned but also because of the delays in the arrival of the UNITA-affiliated Minister of Health to his post[35]. This had an impact on developing a national health policy framework. The lack of central policy guidance had knock-on effects for the provincial delegations, which developed discrete provincial plans. The proliferation of and lack of co-ordination of NGOs working at provincial levels also added to policy incoherence.

Various review missions from this period noted the following problems affecting these projects[36] [37]:

- lack of co-ordination and duplication of efforts between the World Bank, EU and ODA projects
- low absorptive capacity of the MOH
- inability of the MOH to effectively utilise either the technical assistance or financial aid.
- lack of any central policy guidance to the provinces, which functioned in isolation.

The ODA's Review Mission called for a more coherent donor approach, which would draw together the different strengths of diverse agencies. The ODA's HTP, in particular, was considered by WHO to offer a framework for a national 'Health Transition Process', out of which would develop health sector reforms.

> "The overall 'process' framework would provide a guideline in which all health sector donors, including NGOs, would operate, under the overall direction of MOH centrally, assisted by technical advisors"[38].

Lack of capacity and will on the part of the government created an insurmountable problem, however. The Review Mission thus suggested that *"in the absence of any MOH-led coordination mechanism, it is up to the lead donors (WHO, World Bank, and EU with possibly DANIDA) to take this initiative"*[39]. In any case, the larger project, as designed by the ODA, ceased to function after 1998, because of donor withdrawal from the country, linked with the return of hostilities between the MPLA and UNITA at

[33] Key et.al., 1996
[34] Cutts, 1996
[35] Hardiman et.al., 1997
[36] Key et.al., 1996
[37] Pavignani, 1997
[38] Key et.al. 1996:13
[39] Key et.al. 199:13

the end of 1998. SCUK continued with their component of the HTP in Huambo and Benguela provinces, despite the difficulties. This is discussed further below.

In 2001, political reforms led to the decentralisation of power from the central level to the provincial level[40]. This has led to a considerable dilution in responsibility for line ministries, with their *delegacoes provinciais* displaced by the *direccoes provinciais* of the provincial governments. The provincial directors are now appointed by and are accountable to the provincial governors; budgetary allocation and management is also under the remit of the province. Despite the potential for greater accountability, including more relevant priority-setting and planning that the decentralisation programme represents, a WHO report indicates that *"the transfer of responsibilities from the central to the provincial level has not been accompanied by the introduction of elected bodies at provincial level*[41], thus undermining the accountability of the provincial government to their population. Other critical elements for successful decentralisation are human resource capacity and, in the situation of multiple aid actors, co-ordination. As noted by WHO, decentralisation *"has taken place in a context where human resources, institutional capacities and central oversight mechanisms are weak in most of the provinces*[42], particularly in those most affected by the war. WHO also notes that co-ordination mechanisms are under-developed, hampering the effectiveness of programme planning.

Government policy since 2002

With the cessation of the war in 2002, following the Luena Peace Agreement between the Government and UNITA, the needs of the country are urgent and immense. The main priorities are:

- to rebuild infrastructure (roads, bridges, facilities, utilities);
- to de-mine vast tracts of land;
- to ensure security and stability for re-starting livelihoods
- to train and deploy sufficient personnel for health and education services within a framework of pro-poor service delivery
- to begin the process of political reconstruction, in re-orienting a centralised but minimalist government to the tasks of pro-poor governance

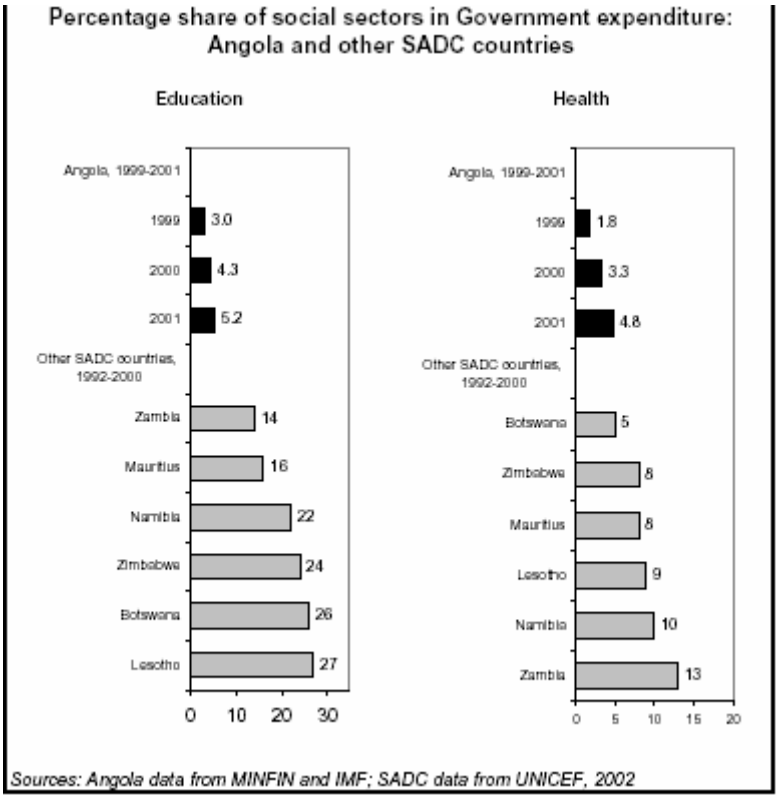
The Government of Angola is slowly being brought into alignment with current global aid instruments. As of April 2004, the Government was preparing an interim PRSP (World Bank, 2004), which could provide a clear policy framework that donors would find acceptable to commit external resources to. The process, however, has been marred by a lack of consultation with Angolan civil society[43].

The interim PRSP includes expanding the public sector's human resources through training and strengthening the capacity of the government's delivery of health and education services. DFID has supported programmes that aim to expose Angolan officials to IPRSP processes in other African countries plus consultants to assist in estimating the costs of the sectoral strategies for the IPRSP. Low priority, however, continues to be given by the Government in the budget to the social sectors, particularly basic social services, nor is it accompanied by a "*pragmatic*

[40] WHO, 2003
[41] WHO, 2003: 11
[42] WHO, 2003: 11
[43] UN OCHA 2004a

implementation plan"[44]. Figure 1 contrasts public social sector expenditure with other countries in the SADC region, showing a wholly inadequate allocation.

Figure 1



With the assistance of UNDP, the Government also launched its objectives for reaching the Millennium Development Goals in July 2003[45]. The Government aims to reduce child mortality by 50% and maternal mortality by 30% by 2008 (with the support of UNICEF and WHO). In support of these goals, the UN's Consolidated Appeal for 2004 aims

> *"to reduce infant and maternal mortality by 5% and 10% respectively, and morbidity by 10% for prioritised diseases by providing the Minimum Health Care Package, focusing on vulnerable groups…increasing the government's leadership in health, expanding the peripheral basic health services, fight against HIV and malaria, formulating sound national health policies, promoting health education, and increasing access to water and basic sanitation*"[46].

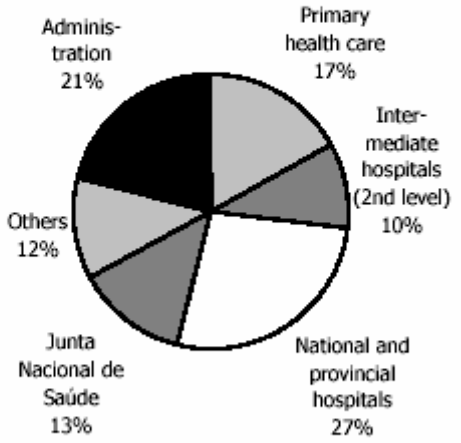
Limited progress has been made, however, in improving the health network. Although the objective was to rebuild a referral system, "*health action is moving timidly from provincial to municipal levels"*[47]. The aim of the Ministry of Health, MINSA, is to support integrated activities building on the activities and successes of the Polio and Expanded Programme of Immunization (EPI) for the benefit of other health activities. The strategy aims to increase EPI and Vitamin A coverage whilst at the same time building up managerial and analytical skills of staff working at the

[44] UN OCHA, 2004c
[45] UN OCHA 2003
[46] UNOCHA, 2003
[47] UNOCHA, 2004a

implementation level[48]. The implementation of such ambitions is limited by the numbers of health workers: a joint UN report[49] reports that *"Angola has only five public sector doctors per 100,000 inhabitants*." Vaccination coverage rates, while improving in accessible areas, are still far below the average of Sub-Saharan Africa while *"only 20% of the population has access to essential drugs*"[50].

The UNDP document also catalogues the level of budgeted and executed expenditure on different levels of service and by geographic allocation, showing minimal allocations to public health and primary health care and large disparities between the coastal provinces ($8.8 per capita), eastern zone ($5.48 per capita), and northern zone ($2.16 per capita)[51]. These distortions, relative to the needs to meet population health priorities and reconstruction of the national health network, require urgent action and external financial and policy support from donors. Indeed, the recent mid-year review of the Consolidated Appeals Process (CAP) for 2004 noted the "*under-funding of strategic planning and technical support for the Ministry of Health, which is undermining the Government's ability to take on its responsibilities"*[52].

Distribution of health expenditure, by levels, 1997-2001



UNDP et.al, 2002:46

With the support of WHO, UNICEF and UNFPA, a Minimum Health and Nutrition Package (MHNP)[53] was put in place in June 2002, divided into a stabilisation phase and a medium term period emphasising institutional capacity building. The MHNP

[48] UNOCHA, 2004b
[49] UNDP et.al, 2002
[50] UNDP et.al, 2002

[51] UNDP et.al, 2002

[52] UN OCHA, 2004c
[53] RoA, 2002

aims to provide basic services to 300,000 people in 52 health units of 15 provinces[54] and involves training health unit managers, integrating former UNITA health workers, strengthening the health information system and disease control response. Support for WHO and essential drug kits to accompany the package has been provided by the EU and other donors.

2.2 Multilaterals

In addition to the health sector projects supported by the World Bank and the UK ODA mentioned above, other bilateral donors, the Netherlands, Norway, Italy, and Belgium also channelled funds through WHO, UNICEF and INGOs during the 1990s for capacity building at the provincial and municipal level, disease control programmes, drug supplies and equipment and emergency assistance[55]. Besides the health sector project of the World Bank, the Bank has supported a Social Fund in Angola since 1994, with mixed results (see below). This is described in the next section.

Fundo de Apoio Social (FAS) – 1994-present

In 1994, the World Bank, along with other donors established a Social Fund, the Fundo de Apoio Social (FAS 1), to get round the "*cumbersome state apparatus and its lack of poverty focus"* [56]. FAS I ran from 1995-1998, FAS II was agreed in July 2000 and FAS III in July 2003; all are financed by a credit from the International Development Association. The FAS is an autonomous governmental agency, with a central management unit hosted by the Ministry of planning, but with project administration and finance decentralised to the provinces. Government representation on the FAS National and Provincial Boards aims to ensure coherence with provincial policy and priorities. NGOs are also present on the Boards. Aims of FAS I were:

- to improve access to basic services
- improve community and partner capacity to initiate and manage projects, and
- support income-generating projects in the rural and peri-urban areas.

A 1998 beneficiary survey indicated that their first priority was education (68%) followed by health services (23%) and, third, water supply. FAS I was perceived to be critical in strengthening social capital, community level democracy and knowledge sharing, which had positive spin-offs for the community-level projects.

A study by Adauta de Sousa et.al[57] noted weaknesses in the FAS I projects:

- a large proportion of projects were urban-based, largely due to the difficulties of access to rural areas, but also because of the erosion of social capital experienced in the rural areas;
- there was a gender-bias in the types of projects supported, with fewer projects benefiting women being supported;
- the poorest communities were not reached.

Coverage was affected by the insecurity prevalent in many provinces, the dislocation of families, and the reliance of households on short-term coping strategies rather than longer-term investment.

[54] WHO, 2003
[55] Key et.al., 1996
[56] Adauta de Sousa et.al, 2001
[57] Adauta de Sousa et.al, 2001

FAS II, agreed in July 2000, followed on from FAS I. FAS III commenced in 2003, and was again supported by a credit from the IDA as well as funds from the European Commission. FAS III aimed to facilitate social and economic recovery at the community level through three main components[58]:

- Community development, through financing locally-identified initiatives to build social and economic infrastructure. Communities and local authorities will be given a greater role in decision-making, planning and management than in the previous FAS. Besides strengthening community-based services, this component fosters social capital creation by bringing communities together to design and implement projects.
- Conflict Impact and Vulnerability Assessment. This component aims to understand the obstacles and opportunities to building/renewing social capital in conflict-affected environments.
- Municipal Development. This component is aimed at strengthening the capacity for planning and resource management of municipal governments in the provision of social and economic services.

The relevance of strengthening social capital as well as human capital has been given a much greater profile in FAS III. The close association between 'community-driven development' and social capital has been clearly identified in literature since the late 1990s. Kawachi et.al define social capital as *"the features of social organisation, such as civic participation, norms of reciprocity, and trust in others that facilitate cooperation for mutual benefit"* [59]. In conflict-affected societies, social capital is often seriously eroded – for example, through continuing forced migration and the destruction of kinship and community networks. In order to build community capacity to take on wide-ranging community based service projects, re-building social capital becomes an important feature. Hence, this represents a potentially important feature of the Social Fund.

Renewed peace – post conflict reconstruction

Following the Luena peace agreement in 2002, the World Bank, UNDP and the EU have shown a willingness to engage with the Government, particularly on the Emergency Demobilization and Reintegration Programme. The World Bank is engaged with the Government in three ways: first, through the 'Transitional Support Strategy' (TSS)[60]; second, through a grant supporting a government HIV/AIDS project; and third, as a pilot 'LICUS' country in partnership with UNDP (see box). The TSS includes a third credit from the IDA to extend the Social Fund – FAS III, which supports community-based service delivery.

World Bank/UNDP LICUS Partnership Initiative

"In the context of the Low-Income Countries Under Stress (LICUS) initiative, the Bank and UNDP are preparing a framework for collaboration in several key areas in Angola. These include: i) governance and transparency; ii) service delivery; and iii) capacity building. …

[58] World Bank 2003b
[59] Kawachi et.al, 1997:1491
[60] World Bank, 2003a

> *In the area of service delivery, besides close cooperation between UNDP's Basic Rural Service project and the Bank's complementary Social Action Fund (FAS), UNDP will take an active part in implementing the Bank-led ADRP [Angola Emergency Demobilization and Reintegration Project]."* …
>
> World Bank, 2003a

The UNDP also supports the government in "upstream strategic policy support"[61], including specific programming on the following:

- poverty reduction strategy development;
- strategies to prevent transmission and mitigation of HIV/AIDS;
- formulation and implementation of a decentralisation strategy
- improving public sector efficiency and accountability
- enhancing government support for community empowerment through institutional capacity building
- improving aid coordination mechanisms
- mainstreaming gender

As indicated above, the UNDP has been instrumental in supporting the move by government to a policy-driven decentralisation programme[62]. Decentralisation had existed prior to the UNDP programme but was *ad hoc*, responding to the conditions of war. The transfer of power to elected sub-national government, however, takes place in an environment of low human resource capacity, which will affect the expectations of time to build an effective system. UNDP has advocated a partnership approach at the sub-national level between local authorities and the non-state sector engaged in service delivery. This reflects the reality on the ground of the number of non-state actors engage in service delivery. An example of such partnership arrangements is discussed in the next section under the LUPP.

2.3 International NGOs

Supporting public service delivery during conflict

A significant number of humanitarian agencies returned or resumed relief assistance with the renewed outbreak of war at the end of 1998. In the absence of government programmes and weak co-ordination, the reliance on UN agencies and INGOs inevitably led to a concern that fragmentation, unequal coverage and lack of standardisation constituted serious problems in themselves[63] [64]. A UNDP report underlined the problems:

> According to a provincial governor's opinion, the State fails because it does not define the framework for NGOs and it lacks the mechanisms to verify and monitor their activities. State institution blame NGOs of lack of transparency, of escaping institutional framework systems, of acting outside provincial plans and of failing to co-ordinate their priorities with the provincial governments' and with the municipal and communal administrations. On the other hand, NGOs complain of authority abuses, lack of respect for their identity and autonomy, as well as lack of concrete and executable orientation. As a result,

[61] UNDP 2002
[62] UNDP DATE?
[63] Key et.al., 1996
[64] Pavignani and Colombo, 2001

> the deficiencies in democratic and organizational culture do not favour dialogue and negotiation…"[65]

An alternative approach was presented by SCUK, which following the demise of the HTP project at the end of 1998, continued to focus on building capacity of the public sector in Huambo and Benguela provinces rather than take over as a direct service provider. The emphasis was to:

- strengthen institutional and management capacity with a focus on integrated resource management,
- improve organisational practice,
- integrate supervision and in-service training,
- enable provincial managers to gain experience with budgeting through incremental budget support[66]

The proponents of the approach clearly considered its merits – efficiency gains, staff morale boosting, context-driven, service integration, growing accountability – to offset the difficulties of working in *"an unstable, disrupted environment, where stress, uncertainty and short-termism prevail"* [67]. Other INGOs also supported the provincial level health ministries and the municipalities.

INGO delivery – post-conflict

According to the UN Common Country Assessment for 2002, donors have *"tended to channel most assistance through UN agencies and NGOs, rather than Government ministries"*[68]. Yet, even assistance to the UN and INGOs through the Consolidated Appeals has been negligible relative to need: one-third of the funds requested for 2003 were raised [69]and, as of March 2004, "*only three out of 45 appealing organisations had received funding through the UN Consolidated Appeal for 2004*"[70].

In the CAP 2004, 21 INGO projects (14 INGOs) are listed as part of the appeal to raise funds for public health projects distributed throughout the country, including nutrition rehabilitation, PHC, reproductive health, HIV/AIDS, and water supply and sanitation[71]. From the range of INGO proposals in the CAP, the following activities are proposed:

Activity	No. of projects
Rehabilitation of existing health posts	4
Construction of new health posts	5
Equip and run a mobile clinic	2
Cost recovery	2
Establish/support health information system	2
Supply essential drugs	6
Supply medical equipment to municipal hospital	2
Supply medical equipment to health posts	6
Train health staff	12

[65] UNDP, DATE : 62
[66]CPHA/LSHTM, 2000.
[67] CPHA/LSHTM, 2000
[68] United Nations, 2002
[69] Angola Peace Monitor, November 2003)
[70] reliefweb March 2004
[71] UNOCHA, 2003

Train community health workers	3
Train TBAs	6
Build community awareness – HIV/AIDs; hygiene promotion;	15
Nutrition rehabilitation	1
Construct water points	7
Establish water and or latrine committees	8
Build basic sanitation facilities	8

The Mid-year review of CAP 2004 notes, however, the "general under-funding of NGOs"[72], which is *"hampering interventions in municipalities where government capacity and human resources are still very limited."* The same review notes the tendency of agencies and NGOs to *"favour a geographic and/or sectoral approach*;" in the field, responses remain "'vertical and sectoral' rather than 'horizontal and integrated'"[73]. As of the 10 June 2004, only one of these INGO projects had been funded. Other NGOs, such as GOAL and International Medical Corps, have been funded by bilateral donors outside the CAP appeal.

Meeting in April 2004, the Humanitarian Co-ordination Group noted that "*funding shortages [are] severely affecting implementation of basic social services*" and that "*funds for emergency projects have ended while development programmes [for the] transition appears to be 'frozen'*"[74]. The table in Appendix 1, from the DFID Country Engagement Plan, 2003, indicates the areas and level of spending allocated to humanitarian and development activities by different donors.

2.4 Partnerships: local government, INGOs, local NGOs

The UNDP and other donors are supporting a range of partnerships between local governments and non-state actors, mainly INGOs and local NGOs. Although limited in number, a number of partnerships exist in different provinces[75]. Examples of partnerships described in the UNDP report are given in the box below, followed by details about LUPP.

> *"In the Municipality of Bibala* [Namibe province]*, three local NGOs are members of the Municipal Council and take part in the decision-making process. This is a local initiative that has been praised by social partners and should be valued and promoted as an example of citizen's participation in the local administration, as it is recommended in the Strategic Plan for Deconcentration and Administrative Decentralization. In Gambos* [Huila Province]*, the Administration invites three NGOs (one international – ACCORD, one national – ADRA, and one local – Grupo Estrela) to participate in the Municipal Council, thus benefiting from their assistance in improving forms of intervention in communities from an integrated development perspective. In Kilamba Kiaxi* [Luanda] *there is a discussion forum between the community*

[72] UNOCHA, 2004c
[73] UNOCHA, 2004c
[74] UNOCHA, 2004a
[75] UNDP DATE?

organizations, local NGOs and the Administration – which was suggested and activated by an international NGO (CARE)".[76]

2.5 Luanda Urban Poverty Programme 1999-present

Even as the civil war intensified in 1999, leading yet again to a vacuum in state-directed development, DFID initiated a poverty reduction programme in Luanda, partly in response to the number of IDPs fleeing into the city. Again, this programme was counter to the trend of much relief funding, which targeted the conflict zones rather than Luanda[77]. The Luanda Urban Poverty Programme (LUPP), launched in 1999, focused on improving the livelihoods of the urban poor and supporting community-based basic services[78]. Funds for the project were channelled through three INGOs: Development Workshop/One World Action, Care, and Save the Children UK.

The Sustainable Communities Services Programme (SCSP), one of LUPP's sub-programmes, was implemented by Development Workshop (DW), an INGO that has worked in Luanda's *musseques* since 1981. DW emphasises the building of local social capacity and partnerships over the long term with local government and community stakeholders, utilising community mobilisation to motivate and support communities [see box].

Sustainable Communities Services Programme

"*The Sustainable Communities Services Programme works in the musseques with the aim of piloting new forms of partnership in service provision but also of creating space for participative politics by poor peri-urban residents… An essential part of the programme is building up local organizational strength so that neighbourhood services committees can achieve a degree of autonomy and can successfully negotiate with the local government and service providers, such as the water company. The project helps to lay a basis for future local-level democratic governance. Local community leaders involved through the project today are likely future municipal or local government councillors. The forum created by the project provides space for negotiation on provision of services, as well as an opportunity to coordinate activities on basic sanitation and solid waste collection. The focus on practical activities that are of high interest to the peri-urban poor as a basis for this level of organizational development is fundamental, as is international support from donors…in ensuring this new initiative gets the attention of the local government and service providers"*[79].

The LUPP programme has been extended until 2006. LUPP2, valued at £9 million, will focus on influencing policy debates and promote the scaling-up and replication of successful models for basic services delivery. DFID continues to support INGOs in

[76] UNDP DATE: 63
[77] Aegisson, 2001
[78] DFID, 2003
[79] Jenkins et.al., 2002

working with local civil society groups, including the Sustainable Community Service Programme of Development Workshop.

The UNDP points out the differences in capacity between INGOs and local NGOs:

> *"International NGOs have access to more human and financial resources, yet they face the disadvantage of being 'more distant' from the population and knowing less about its idiosyncrasy and culture, except in some cases of longer time spent in Angola* [e.g. Development Workshop] *and (sometimes exclusive) use of Angolan staff – including leadership positions at high levels. The capacity of local NGOs for delivery of services is often weak due to unskilled staff, financial dependence, organisational and management weakness, concentration in urban centres – and, mainly in Luanda and Lubango, low capacity to negotiate with the State and to influence it and often, the lack of an integrated intervention perspective with a multi-sectoral character and a participatorial development basis. However, they possess some strengths that should be highlighted:*
> - *growth dynamics and credibility*
> - *sense and exercise of citizenship*
> - *political and organisational pluralism*
> - *ability to function as a pressure group*
> - *identify with community-based groups*
> - *ability to facilitate people's participation"* [80]

These examples of partnership require further analysis and support from donors in the interests of service delivery, accountability and strengthening citizenship.

[80] UNDP DATE: 62

3 ANALYSIS OF STRENGTHS AND WEAKNESSES

3.1 Impact on vulnerable people

Service delivery remains weak across the country. Routine immunisation remains lower than for other Sub-Saharan African countries[81]. Malaria was, and remains, one of the main causes of child death[82]; despite the reasonable statistic of 61% access to anti-malarials for the under-fives indicated in the table above, widespread resistance to chloroquine has made the main drug available ineffective[83]. With health personnel and functioning health posts still extremely limited, few pregnant women are attended by trained health workers, resulting in one of the highest global maternal mortality ratios[84]. Huge variations are noted between urban and rural areas, with only 25% of rural women assisted by skilled attendants, and between different geographical regions [85]. In general, the poorest women (lowest three quintiles) continue to rely on traditional birth attendants or assistance from family members[86].

The HTP programmes that supported the strengthening of the provincial 'delegates' during 1990s aimed to build their capacity in management and planning with a view to ensuring that some longer-term impact would be sustained. An attempt was made to build on vertical programmes such as immunisation to develop the provincial managers' experience in providing a more integrated service. Despite the physical rehabilitation of health facilities in the three provinces covered by the project (which ran for only 3 years), service delivery remained limited to the urban and peri-urban areas, hampered by access to rural areas (for reasons of insecurity, including landmines), unsustainable supply lines (drugs supplied by ECHO), inadequate information for planning and monitoring and limited community outreach[87]. However, this should be considered an achievement in the circumstances confronting the country at that time. Without the project, the services delivered and the experience gained by the health staff would not have been possible. Such support frequently provided the only resources the provincial ministries of health had. The ODA's Review Mission in 1996 also clearly indicates that one of the objectives of building the capacity of the provincial health delegations was to encourage them to make demands on the centre in an attempt at accountability.

Reliance on external agencies to deliver social services is high, yet experience indicates that service delivery in a policy vacuum leads to ineffective and inefficient service provision by any actor[88]. Strong co-ordination by central/provincial authorities, difficult at the best of times, of the multiple actors in the field is also necessary[89]. Cain et.al.[90] argue, for example, that the return of humanitarian agencies, following the renewed outbreak of war at the end of 1998 up to 2002, and their propensity to establish delivery systems parallel to national structures and institutions, *"resulted in the accelerated degradation of national service provision, structures and systems*." However, in the circumstances of the war between 1998-2002, the state was not

[81] UN 2002
[82] UN 2002
[83] Iley, 2004
[84] UN 2002
[85] Republic of Angola, 2003.
[86] Republic of Angola, 2003.
[87] Key et.al., 1996
[88] CPHA/LSHTM, 2000
[89] CPHA/LSTHM, 2000
[90] Cain et.al., 2002

interested in service delivery, leaving the field almost entirely to humanitarian agencies. In such situations, relief agencies need to follow agreed guidelines for humanitarian action, for example, as represented by the Sphere guidelines[91].

The polarisation of responses to survival and sustainability by humanitarian and development agencies, however, undermines the development of integrated and coherent policies and structure. In this environment, the UKODA HTP project and the SCUK approach offered an alternative to the humanitarian agencies in continuing to support the provincial structures to meet the new demands placed on them by the war. This clearly represents a model to examine for replication in similar circumstances.

The new partnership programmes, bringing together communities and local governments, also contribute to reducing the vulnerability of people through strengthening social capital and their capacity to organise. Often, these are the building blocks for service delivery in difficult environments. Such initiatives help communities to collaborate, to dialogue with service-providers and to orient the providers to a client-focus[92]. In such difficult contexts, however, after years of erosion, better understanding of the strategies that could be used to build civil society and social capital is needed.

3.2 Impact on state accountability

Accountability mechanisms continue to be under-developed. "*The idea of accountability is little known, and few people have experience of it*"[93].

The Angolan state's accountability is at the heart of the impasse in its relationship to external assistance and to Angolan citizens. As stated at the beginning, a stand-off continues to exist with donors setting a condition of greater transparency regarding revenues and expenditure in the government's own programmes before committing assistance.

In relation to service delivery, the evidence shows that the government continues to give low priority to the social sectors or even broader development policy. Besides a considerable lack of political will, policy-making and implementation capacity is weak. The decentralisation programme, shifting decision-making authority from the centrally-controlled line ministries to the provincial governments, was undertaken before strengthening the policy-making and oversight capacity of the central Ministry of Health, MINSA. WHO[94] explains that this has left the provinces adrift, with few mechanisms in place to ensure policy coherence or accountability. More work is needed to understand fully the sequencing and structures required for decentralisation programmes in difficult environments. Support to the state sector is urgently needed to develop these structures and capacity further.

However, decentralisation is an important element in developing accountability as it also enables the development of partnerships between local government and non-state actors. Programmes such as the LUPP and FAS have the potential to develop a stronger accountability culture at the grass-roots as well as strengthen the capacities of local people to organise. The NGOs – both local and international –

[91] Sphere guidelines [CHECK]
[92] Paul Robson, personal communication, September 2004
[93] Paul Robson, personal communication 15 September 2004
[94] WHO 2003

involved in these programmes have contributed to developing experience by local government and civil society in how to communicate and to collaborate on planning and delivering essential services.

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APPENDIX 1: SUMMARY OF INTERVENTIONS BY OTHER DONORS

Summary of interventions by other donors

Donor	Principal Activities	Humanitarian Spend 2003*	Development Spend 2003*
World Bank	DDR (through the ADRP), Public expenditure management (EMTA), Social Action Fund (FAS III) and HIV/AIDS	N/A	ADRP - $30m over 4 years EMTA - $17m over 4 years FAS III -$58m over 5 years HIV - $20m over 4 years
EC	Humanitarian, Health, Education, Food Security, Governance	$43.5 m	$65 m
ECHO	Humanitarian, Health, Nutrition, Logistics	$8.7 m + any emergency decisions	N/A
France	Humanitarian, Health, Education	$16.3 m	$12.75 m
Germany	Humanitarian	$10 m	N/A
Italy	Humanitarian, Health, Agriculture, Infrastructure	$15.2 m	$12 m
Netherlands	Humanitarian, Human Rights, Peace-building	$11 m	N/A
Norway	Humanitarian, Social Services, Strengthening Civil Society, Demining, Energy and the Environment	$7 m	$14 m
Portugal	Humanitarian	$2 m	N/A
Spain	Humanitarian, Health, Education, Agriculture, Fisheries, Human Rights	$5 m	$1.6 m
Sweden	Humanitarian, Child and Maternal Health, Demining, Strengthening Civil Society	$11.8 m	$5.3 m
Switzerland	Humanitarian, Health, Food Security and Peace-building	$6.5 m	N/A
USA	Humanitarian, Health (inc. HIV/AIDS), Agriculture, Food Security, Governance	$99 m (inc. about 60% in-kind food contributions)	$29 m

* Total contribution for 2003 as estimated by donor in February 2003

Table from DFID, 2003.