WHO COUNTRY COOPERATION STRATEGY: ANGOLA

2002–2005

World Health Organization
Regional Office for Africa
Brazzaville

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CAP	Consolidated Appeal Process
CAPEL	Coordination of Paediatric Services in Luanda
CCM	Country Cooperation Mechanism
CDC-Atlanta	Centers for Disease Control and Prevention
CONGA	Committee of International NGOs in Angola
COO	Country Office Operation
CPC	Communicable Disease Prevention, Eradication and Control
DFID	Department for International Development, UK Government
DOTS	Directly Observed Treatment, Short-course
DRC	Democratic Republic of Congo
EHA	Emergency and Humanitarian Action
EU	European Union
EU	European Union
FONGA	Forum for NGOs in Angola
GDP	Gross Domestic Product
GF	Global Fund against HIV, Malaria and Tuberculosis
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HSD	Sustainable Development
ICC	Inter-Agency Coordination Committee
IDP	Internally Displaced Person
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IOM	International Organization for Migration
IVD	Immunization and Vaccine Development
KAP	Knowledge, Attitudes and Practice
Kz	Kwanza
Kzr	Readjusted Kwanza
MICS	Multiple Indicator Cluster Survey
MINARS	Ministry of Social Reintegration
MINSA	Ministério da Saúde Angola (Ministry of Health)
MOH	Ministry of Health
MPS	Making Pregnancy Safer
OCHA	Office for the Coordination of Humanitarian Affairs
OSD	Organization and Services Development
POA	Plan of Action
PR	President
PRSP	Poverty Reduction Strategy Programme
RO	Regional Office/WHO
SADC	Southern African Development Community
SIGFE	Integrated State Financial Management System

SM	Safe Motherhood
SMP	Staff Monitored Programme
SWAp	Sector Wide Approach
TB	Tuberculosis
TG	Thematic Group
UAN	Agostinho Neto University
UK	United Kingdom
UN	United Nations
UNCCA	United Nation Common Country Assessment
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNITA	National Union for the Total Independence of Angola
USA	United States of America
USAID	United States Agency for International Development
UTCA	Unidade Técnica de Coordenação das Ajudas (Technical Unit for Coordenation for
WCO	World Health Organization Country Office
WFP	World Food Programme
WHO	World Health Organization

1. Introduction

Significant changes in international health and the new situation in Angola following the ceasefire of 4 April 2002, make it imperative for WHO to reflect on its role and the future directions of its work in Angola. In collaboration with the MOH and other partners, WHO has had to analyze its new challenges and responsibilities in providing support to the country within the context of the current environment.

The result of this consultative process led to the definition of the WHO Country Cooperation Strategy (CCS) as a reference framework for WHO work in Angola during the medium term (2002–2005). Through the proposed focus outline in this document, WHO seeks to enhance its intervention strategy of cooperation so as to better meet the current challenges and needs of the country. The strategic thinking on how the Organization can improve and fulfill its cooperative role in Angola takes into account its specific mandate, technical capacity and expertise to complement the actions of partners and stakeholders.

This document constitutes the outcome of a broad participative process and dialogue which included the Ministry of Health; participants from the Government of Angola (GoA); Ministries of Planning, Family and Gender, and Social Reintegration; Provincial Government, amongst others. National NGOs, international NGOs and bilateral cooperation partners (Sweden, United States, Italy, Norway, European Union, France, to list a few) further contributed to the process. In-house brainstorming exercises, meetings, retreats, workshops and two joint missions with representatives of the three levels of the Organization constituted the main tools for reflection on the inputs received from the various partners. The Millennium Declaration of the United Nations,[1] the contemporary development of a UN Common Country Assessment (UNCCA) carried out in 2001–02, has also been essential to the preparation of the CCS. In addition, the Study on Social Sector Expenditure implemented by WHO, UNICEF and UNDP with collaboration from IOM and the Ministries of Finance, Health and Education in 2002 have been instrumental to the results obtained through the CCS exercise.

In view of the arduous transition the country is currently undergoing, it is of great importance to look at the outcome of the CCS exercise and this document with a degree of flexibility and leave it open to revision whenever the need arises. Various factors suggest that both the national policies and the response of the donors cannot be linear. These factors include the pace of consolidating peace, the national reconciliation process, enhanced security, the return and resettlement of refugees and displaced persons, and reintegration or integration of UNITA soldiers into civil society and the National Armed Forces. The implementation of this strategy therefore is extremely challenging.

The document was prepared by WHO and its partners over an 18-month period from September 2001 to February 2003 and is a synthesis of the views expressed during the exercise. The intention is to re-design the WHO role and priorities during the four-year period, 2002–2005.

[1] Millennium Declaration, Millennium Summit, New York, 6-8 September 2000. Resolution A/RES/55/2, 8 September 2000.

2. People and Government: Health Development and Challenges

2.1 From civil conflict to sustainable development

With brief intervals of uncertain peace, the recent history of Angola has been characterized by almost four decades of devastating war. In the past, after the country was a ground for confrontation between the politically opposed blocs of the "Cold War", major economic interests, domestic and foreign, fueled and sustained the war.

The legacy of this past has seriously impacted on all fields of society and the lives of most Angolans. The intensity of war during the last decade induced large population displacements which accelerated the process of urbanization and worsened the social situation. In spite of the enormous natural wealth of the country, the principal indicators of human development place Angola amongst the most underprivileged countries in the world. In 2001, Angola was ranked 146th with regards to the Human Development Index.[2] In the same year, WHO placed Angola 181st with regards to the Health System Success Index.[3] According to official data,[4] adult literacy is 66.8% and access to appropriate sources of water is 61.6%; 46.4% of the urban population and 22% of the rural inhabitants have access to drinking water.[5] As per the Human Development Report,[6] life expectancy at birth in 1999 was 46 years for men and 43 for women.

The high levels of intensity of the armed conflict in many provinces resulted in huge movements of people from unsafe areas to the provincial capitals. Towards the end of 2001, the UN and GoA estimated that more than four million internally displaced persons (IDPs) accounted for nearly one-third of the total population of the country. In the past months, migration towards the cities and displaced persons in camps continues to be on the rise. This has placed a growing strain on the agencies that provide aid as well as on the residents of those areas. The vital needs of the displaced persons have created a huge burden on residents who have had to contribute from their meagre resources. The early assessments carried out by MOH and partners in these areas were indicative of appalling conditions faced by these persons.[7] There are high levels of severe malnutrition, and the effects of the lack of access to basic services (i.e. poor coverage of immunization, high prevalence of communicable diseases, pregnancy complications and chronic diseases) will be enormous. Only with the gradual opening of formerly inaccessible areas will it be possible to assess how serious the humanitarian crisis is and thus quantify the priority needs of the population.

[2] Human Development Report, UNDP, 1991.

[3] WHO, Overall Health System Attainment, World Health Report, 2001.

[4] INE, Multi Indicator Cluster Survey (MICS) 2001.

[5] Ministry of Energy and Water, Water National Directorate, 'Estratégia e Plano de Desenvolvimento do Sector de Águas - Abastecimento de Água e Saneamento; Reunião Metodológica e de Balanço do Sector de Água e Saneamento', Luanda, 13-16 February 2001.

[6] UNDP, Human Development Report 2001: Making new technologies work for human development, New York, 2001.

[7] Rapid Assessment in the Family Quartering Areas, June 2002, MOH, WHO, UNICEF, UNFPA.

A further aggravation impacting on the return and resettlement of displaced persons is the presence of landmines, making agricultural production and delivery of health services very difficult. Angola is deemed to be the country with the highest number of landmines in the world. It is estimated[8] that 35% of the national territory is infested by seven million mines. Official data indicate that 963 people (403 of whom died) were victims of landmine incidents in the year 2000.

In June 2002, according to the estimates made by OCHA[9] on the size of the vulnerable population, the facts presented were:

(a) approximately 1.9 million people living in areas accessible before the peace agreement of 4 April were in very difficult situations;

(b) another one million vulnerable persons were settled in newly accessible areas;

(c) approximately 390,000 former UNITA cadres were collected in the Quartering Family Areas; 457,492 persons, according to UNHCR,[10] had been registered in 2001 as refugees and are currently living in Zambia, Democratic Republic of Congo (DRC) and Namibia;

(d) the high HIV prevalence, approximately 20%, currently existing in the countries that have been hosting Angolan refugees for years needs to be addressed with special focus and strategies. The social and humanitarian situation is not only serious in the countryside, but also in cities, including Luanda, where refugees have low access to food and very limited access to basic services.

The recent Peace Agreement signed on 4 April 2002 has thrown open the door for new opportunities and at the same time created new challenges for the country and the entire international community. Although this is not the first peace agreement, most observers feel that the current political and military scenario has radically changed in 2002 since the ceasefire took effect, clearly pointing at prospects for a lasting peace.

2.2 General demography

Angola is characterized by a number of ethnic groups, cultures and traditions, national languages and behaviours. The last official general census was carried out in 1970, and the total population was approximately 5,673,000 with a density of 4.55 per sq km.[11] Current population estimations[12] are now around 14.6 million with an average density of 11.7 per sq km. Other recent estimations from the national EPI confirm a general population of around 14.5 million.[13]

2.3 Economic situation

In parallel with the decline or stagnation of most sectors of the economy, the growth of the petroleum industry has featured in the post-independence period. The oil sector has become the country's main source of export earnings and the main source of fiscal revenue for the government. In 2001, the oil sector accounted for 61% of gross domestic product (GDP).

[8] UN Common Country Assessment and Strategy (UNCCAS), Luanda, April 2002, p 11.
[9] UN, Bridging Request: Humanitarian Operations in Angola, June, 2002.
[10] UN, UN Common Country Assessment and Strategy (UNCCAS), Luanda, April 2002, p 10.
[11] National Plan for Health Development 2002-05, Dec 2001, Fourth Draft, MOH.
[12] National Plan for Health Development 2002-05, Dec 2001, Fourth Draft, MOH.
[13] Expanded Programme for Immunization, Estimated Population for 2001, Luanda, June 2001.

On average, government expenditure from 1997 to 2001 has been equivalent to 48.9% of GDP. The expansion of oil production, which has reached 900,000 barrels a day, has provided the government with large revenues, exceeding US $3 billion in 2001.[14] This resulted in Angola having one of the highest ratios of government expenditure to GDP, among African countries. On the other hand, the heavy dependence on oil makes the country vulnerable to fluctuations in petroleum prices. The predominance of the oil sector in the makeup of the GDP (57% in 2000) is a source of concern, due to the poor effects this sector has had on employment and the other areas of production. In actual fact, in a country where agriculture is the source of survival for most of the people, the production of grain in 2001 met less than 50% of the country's needs. This situation is further worsened by the percentage of arable fields currently polluted by landmines.

In spite of the exploration of new oil wells and the growing production of diamonds, the rise in GDP (3.3% in 2001)[15] was less than expected (see Table 1), and the external debt, standing higher than US$ 10 billion, continues to be a source of concern. In 2000, the GDP per capita stood amongst the lowest in the southern and eastern African region, coming only before Tanzania, Malawi and Mozambique.[16] Compared with other countries in the region, the rise in GDP in Angola in 2000 was higher than that of Lesotho and Zimbabwe where inflation was higher than that of the neighbouring countries.

Table 1: **Angola: General data on the economy, 1997–2001**

	Source	Unit	1997	1998	1999	2000	2001
Population	INE	Thousands	12,262	12,630	13,009	13,400	13,808
GDP at current prices	FMI	Million $	7,675	6,445	6,088	8,864	9,472
GDP per capita	CCA	$	590	495	468	661	686
Inflation (annual, Luanda)	INE	%	148	135	329	268	116
Average exchange rate (official)	BNA	Kz/$	0.23	0.39	2.84	10.2	22.1
Average exchange rate (parallel)	BNA	Kz/$	0.30	0.61	3.16	10.6	23.9
Average petroleum price	FMI	$/ barrel	18.6	11.9	17.6	27.1	23.0

Source: Government of Angola/WHO/UNDP/UNICEF/IOM, Public Financing of the Social Sectors in Angola, 2002, p 2.

2.4 Governance, public sector reform and poverty reduction

The main formal mechanisms for the accountability of those in power to the population are the electoral and parliamentary systems. The Constitution, which was revised in 1991–92, provides for presidential elections every five years and parliamentary elections every four years, under a pluralist political system that allows for open competition between rival parties. Meanwhile, the state of insecurity has prevented the holding of new presidential and parliamentary elections since those held in 1992. Indeed, UNITA's return to war at the end of 1992 prevented even the conclusion of the 1992 presidential elections and the mandates of both the National Assembly and the President have been extended on security grounds.

[14] Government of Angola/WHO/UNDP/UNICEF/IOM, Public Financing of the Social Sectors in Angola, 2002 p.2.

[15] Angola, Common Country Assessment, 2002, p. 15.

[16] Angola Country Profile, The Economist Intelligence Unit, February 2002.

Between elections, the National Assembly has the constitutional function of ensuring the accountability of the government. The President of the Republic is an executive president who chairs the Council of Ministers and shares executive power with the Prime Minister. In fact, the President's role is greater than this, since there has been no Prime Minister for the last three years. The Parliament is responsible for approving legislation, including the General State Budget, but not decree-laws and decrees, which are adopted by the Council of Ministers. The government issues decree-laws under legislative authority granted by the National Assembly. It also has the right to question government ministers and to obtain from government institutions whatever cooperation is needed in order to perform its duties. The strategy that is underway regarding approaching the broad perspective of public administration reform can be read as one of "negotiation and mediation" in order to create ways to address the challenges which will translate directly to population welfare, equity, social justice, economic growth, etc.[17]

The education sector has started a process of structural reform by means of a new law approved in 2001.[18] Its objective is to modernize the teaching system.[19] Actions are underway to enhance the efficiency of public spending, with implications on the reformulation of the budgetary structure. For example, the Administrative Services Reform Programme aims to cut back the staff in the civil service by 20%. The State Budget for 2002 commits the government to greater fiscal and monetary discipline, which includes measures to generate new revenue through value-added tax (VAT) and focuses on the modernization of the customs system.

In 2001, the Staff Monitored Programme (SMP) with the IMF ended. Its purpose was to promote macroeconomic stability, increase transparency in public sector operations and begin the implementation of crucial structural reforms. The SMP also included a state budget redistribution policy for social sectors based on a strategy to alleviate poverty which would help guide the government's policies and spending for the most vulnerable social groups. However, in the last IMF mission, it was observed that in spite of the progress made, the implementation of measures taken proved insufficient.[20]

Power at the subnational level is concentrated in the 18 provincial governments and in particular their governors who are nominated by the Head of State. Since the 1990s, the Provincial Governments have gained, at the expense of the central ministries, the decentralization of administrative responsibilities from central to provincial levels (Decree 17/99, Decree-Law 29/00, Decree 27/00). The most important change has been the conversion of the line ministries to the provincial governments. Their directors are now appointed directly by the provincial governor to whom they are accountable, and their budget allocations are part of the provincial government budget (Decree 2/00 of May 2002). Although there has not been any significant fiscal decentralization, the increased role in budgetary management has led to the creation of budget management units in the provincial government, and the negotiation of their budgets are done by the provincial governments directly with the Ministry of Finance without involvement of the sectoral ministries. This has created a situation where the line ministers have no means to engage in meaningful sector-wide planning and programming, in particular with respect to basic social services such as primary health care, which is now the full responsibility of the provincial government.

[17] MAPESS; Estudo sobre a Macro-Estrutura da Administração Pública Angolana: Uma abordagem preliminar; Programa de Reforma Institucional e Modernização Administrativa; CDI/MAPESS; May, 2000.

[18] Government of Angola, Lei nº 13/01: Lei de Bases do Sistema Nacional de Educação, Diário da República, nº 6, 31 Dicember 2001.

[19] Vinyales L. O. Financiamanto público dos sectores sociais em Angola, UN/Princípia, Luanda, 2002.

[20] IMF, Angola: Preliminary Conclusions of the IMF Mission, International Monetary Fund, 14 August 2001.

The challenge now is to ensure that sectoral ministries can play an effective role in sector-wide planning and budgeting. This will ensure that provincial governments and municipal administration meet their obligations with respect to national policies and standards. At the sub-provincial level, the 163 *municipios* and the 532 *comuna* serve as the functional departments of the provincial governments. The transfer of responsibilities from the central to the provincial level has not been accompanied by the introduction of elected bodies at provincial level which would create more accountability of the provincial government to the populations under their authority. Moreover, this decentralization of authority and responsibility has taken place in a context where human resources, institutional capacities and central oversight mechanisms are weak in most of the provinces. During the conflict, there was an exodus of government employees, even more accentuated for those of higher level, leaving the worst war-affected provinces of the interior, towards the capital, Benguela and Huila.[21] In a census carried out in 1998,[22] 73% of all *técnicos superiores* and 42% of *técnicos medios* of all professional staff were shown to be in Luanda.

The National Institute of Statistics estimates that 68% of the population are currently facing poverty, of which 26% are living in abject poverty.[23] Surveys in urban areas over the years have indicated that the level of poverty has risen due to the influx of displaced persons into cities and the dearth of job opportunities, mainly in the formal sector. The protracted war is not the only explanation for the deterioration of living conditions; the high inflation rates (with a major impact on the purchasing power of salaried workers), the unemployment rate and the drop in public social services supply have made for this catastrophic situation.

As regards the gender issue, indicators suggest that women enjoy a quality of life, levels of literacy and economic opportunities far lower than men do.[24] A study from the National Institute of Statistics[25] reveals that literacy has not reached 16% of men and 46% of women. Among rural women, 66% were found to be illiterate. Most women have access to unskilled jobs, mainly in the informal sector (where two-thirds of the jobs are done by women). Amongst the Members of Parliament, women account for only 16%, and only 13% are members of the government. In the civil service, women account for 40% of the staff.[26]

Since a year ago the country has embarked on the elaboration of an Interim Poverty Reduction Strategy Programme which is still in the consultative process. Health and education are the two key sectors that the I-PRSP are looking at as the strategic sectors to be focused on, with specific programmes in order to reduce poverty in the country.

[21]UN, Angola: The Post-War Challenges, Common Country Assessment, 2002.
[22]MAPESS, Perfil dos Recursos Humanos da Administração Pública, Luanda, February, 1999.
[23]Ministry of Planning; 'Estratégia Interina de redução da pobreza', February, 2001.
[24]UN, Angola: The Post-War Challenges, Common Country Assessment, 2002.
[25]INE, /Resultados dos indicadores Múltiplo, MICS2,2001, Folha de Informação rápida/, April 2002.
[26]Angola, Common Country Assessment, 2002.

2.5 Health profile

The status of health of Angolans, as reflected by the main indicators, is among the worst in the world. The maternal mortality rate was estimated in 1995 at 1,300 for 100,000 live births,[27] and other estimations consider it at 1,850.[28] In 2001, infant mortality was 150 for every 1,000 children under one year while the mortality of children under five was estimated at 250 per 1,000 children[29] (Table 2).

Table 2: **Health related indicators**

Health and Social Indicators	per thousand	%
Infant mortality rate	150	
Under-five mortality rate	250	
Global malnutrition		30.5
Acute global malnutrition		42.2
Access to appropriate water source		61.6
Access to appropriate sanitation		59.4
Access to antenatal care		65.6
Prevalence in use of contraceptive methods		6.2
Coverage of institutional deliveries		44.7
Iodized salt consumption		34.9
Vit A supplement in children <5		33.8
Vit A supplement in pregnant women		25.8
Rate of exclusive breastfeeding		13.6
DPT 3 coverage		33.9
Measles vaccination coverage		53.4
Polio 3 vaccination coverage		63.2
BCG vaccination coverage		68.8
TT vaccination coverage in children < 5		62.2
Oral rehydration salt (ORS) use in diarrhoea		39.9
Home care protection in case of diarrhoea		7.0
Utilization of health care services in case of diarrhoea		58.0
Utilization of mosquito nets		10.8
Utilization of antimalaria health care services in case of malaria		63.0
Knowledge on how to avoid HIV infection (women 15–49)		17.4
Knowledge on erroneous concepts about HIV/AIDS		14.3
Knowledge on HIV mother-to-child transmission		47.1
Women with discriminatory attitudes re PLWHA		43.5
Women knowing where HIV test can be done		22.8
Women who did HIV test		1.8

Source: MICS 2001 - INE, November 2001.

It is important to underscore that these indicators, being national aggregates, can possibly "conceal" major variations between geographical areas and the most vulnerable population groups. The most up-to-date information on malnutrition and mortality in some areas of the country is available from rapid assessments carried out by MOH and WHO in the past months. Although major variations have been recorded, according to the area where surveys were conducted on the target population group, the results indicate levels of malnutrition and mortality above the standards of alert and, in some cases,

[27] OMS/UNICEF/FNUAP, Maternal Mortality in 1995: Estimates Developed by WHO, UNICEF, UNFP; OMS, Geneva, 2001.

[28] MINSA, Plano Estratégico Nacional de Saúde Reprodutiva, Luanda, 2002.

[29] INE, Resultados dos indicadores Múltiplo, MICS2,2001, Folha de Informação rápida, April 2002.

emergency. Acute malnutrition in many of the Family Quartering Areas where former UNITA families had been collected in June 2002, showed alarming rates of acute malnutrition.

The country's vulnerability is shown by the frequent occurrence of epidemics due to poor sanitation and water supply systems in the presence of reduced preventive programmes, including low routine immunization coverage. Angola has, over the past few years, faced various outbreaks: poliomyelitis in 1999, with a total of 1,117 children affected; meningitis with 1,263 cases and 152 deaths until October 2002,[30] measles in various provinces with from 7,000 to 15,000 deaths per year.[31]

The currently still poor functioning status of the national information system, including epidemiological surveillance systems, limits the ability to appreciate and monitor the gravity of the status of the health of the population. As regards endemics, according to the available sources, malaria is the main cause of morbidity, with 40% of the children dying in the first five years of life and 25% of maternal mortality associated with malaria conditions. The mortality rate in hospitals stands between 15 and 30%. Regarding the utilization of health services, malaria accounts for around 80% of the demand for care and 50% of the in-patients.[32] According to reports, acute respiratory diseases and diarrhoeal diseases are the second most common causes of morbidity and mortality. All together, according to the recent assessment carried out in the provinces by MOH and partners, the three diseases account for approximately 70% of all causes of morbidity and 60% of all causes of mortality. Around 21,000 cases of tuberculosis (TB) have been registered in the country to date, and around 7,000 new cases are diagnosed every year. In real terms, this should be considered an underestimation of TB incidence since the health network is incapable of screening respiratory patients and avoids doing so due to the fact that TB medicines and the directly observed treatment short-course (DOTS) strategy are still not at hand. Out of 1,463 health facilities in the provinces, only 4% (54) facilities implemented DOTS.[33]

Factors such as the massive destruction of the health network, the deterioration of the socio-economic fabric, the great population movements and HIV/AIDS related diseases are all at the root of the worsening health status of the people in Angola. Some of these factors further explain the poor capacity of the services to detect and treat other chronic diseases, including leprosy and trypanosomiasis. The information available on the trends of infection by HIV/AIDS point to an exponential growth of prevalence rates, particularly in pregnant women and those suffering from sexually transmitted infections. In a survey carried out in 2001 in pregnant women, HIV prevalence was shown to be 8.6% compared to 3.4% in 1999. Also, surveys of sex workers, in 1999 and 2001 demonstrated a rapid increase in prevalence from 19 to 32.8%. The HIV/AIDS situation can greatly deteriorate and could accedente the transmission because of a large population movement that continues to occur with the re-establishment of peace and the brisk opening of international borders. In addition, the pandemic is aggravated by the limited knowledge about this disease, low availability of counselling and antiretroviral (ARV) treatments, and large number of blood transfusions as a result of injuries and wounds caused by war, landmines and parasitic diseases.

[30]CPDE/DNSP; Boletim Epidemiologico semanal week 42, 2002.

[31]MINSA,DNSP,Departamento de Higiene e Epidemiologia,OMS,UNICEF; Plano Estratégico para a redução da mortalidade por Sarampo em Angola, 2002–2005, October 2002.

[32]MINSA, OMS; Análise da situação de saúde: Províncias de Malange, Huambo, Luanda 2002 (draft).

[33]MINSA/National Direction of Public Health, Strategic Plan of National Programme of Tuberculosis Control (NTP) 2003–2007, Luanda, August 2002.

According to official data,[34] about 65% of the health units were destroyed during the war. Most equipment was stolen or deteriorated from lack of maintenance, especially in the peripheral areas. There are huge variations between provinces on the average populations served by health centres, with Cabinda Province showing the best ratio of 9,400 people per health centre and Bie Province the worst with around 460,000 per centre. Six provinces have a ratio higher than 80,000 inhabitants per health centre.[35] Emphasis on primary health care is demonstrated by the national average of 0.7 hospital beds for every 1,000 inhabitants, a low index, but not much different from that of most countries in the region. In terms of distribution, however, the concentration of these resources in the capital does affect the national average in such a way that the lack of beds in the peripheral areas can be misrepresented in the national average. The expansion of the network according to demographic criteria and need, now possible because of the enhanced safety and security, shall correct distortions and achieve better equity to access for services. This will be one of the chief challenges for the Ministry of Health and its partners in the health sector.

The other indicators from Table 2 show how difficult it has been for the system to address the health needs in the context of war. All programmes were tremendously hindered by the conflict. However, in the health sector, the only programme that performed according to plans has been polio eradication. From the more than 1,000 cases of polio in the year 1999, the country only registered one case in 2000, another one in 2001 and, to date, no case in 2002. This tremendous success is due to the strong political commitment and leadership of MOH, good organization by the national stakeholders both at the central and provincial levels, and the positive work done by the partners (WHO, UNICEF, Rotary International, USAID, CDC Atlanta, CORE, UK, the Netherlands, and NGOs in general).

2.6 Health financing

According to a study on social sector expenditure carried out by WHO, UNICEF and UNDP in 2001, the executed expenditure in the period 1997–2001 for the health sector varies from 31 million Kz in 1997 to 5,483 million Kz in 2001. The data cannot be compared from one year to another because of the high rates of inflation during these periods. However, in Table 3 the trends show the percentage share in the social sectors within total government expenditure, using the two sources of data available for the total value of expenditure (SIGFE and IMF). The SIGFE data, which exclude the extra-budgetary expenditure, show that the overall weight of the social sectors remained generally in the range of 20 to 30% of expenditure in the period under review. However, the year 1999 indicates a much smaller percentage of only 12.9%. This reflected the large increase in the expenditures on defence and public order which were related to the revival of armed conflict at the end of 1998. In 2000, there was a recovery in the share of social sectors in government expenditure, which rose to 24.0% in 2000 and 26.3% in 2001. The inclusion of extra-budgetary expenditure in the figures for total expenditure results in a significantly lower weight for the social sectors, ranging between 6 to 19%. The share of the health sector expenditure in total (including extra-budgetary expenditure) fell, as did the education sector, in 1999 to only 1.8% before recovering soon after in 2000 to 3.3% and in 2001 to 5.4%.[36]

[34] MINSA, Diagnóstico da situação da rede sanitáriaVol.1; Cap.V: Estado de conservação das unidades sanitárias, Luanda, 1999.

[35] PNUD, Relatório Desenvolvimento Humano-Angola, Luanda 1997.

[36] Government of Angola/WHO, UNICEF, UNDP, IOM, Public Financing of the Social Sectors in Angola, Luanda, August 2002.

Table 3: **Percentage share of the social sectors in executed Government expenditure, 1997–2001**
(by functions, excluding debt amortization)

	As % of total expenditure, excluding extra-budgetary expenditure					As % total expenditure, including extra-budgetary expenditure				
	1997	**1998**	**1999**	**2000**	**2001**	**1997**	**1998**	**1999**	**2000**	**2001**
Education	7.5	14.9	6.6	9.2	9.0	4.0	6.1	3.0	4.3	6.4
Health	5.2	8.0	3.8	7.1	7.7	2.8	3.2	1.8	3.3	5.4
Social security and social welfare	5.4	4.0	1.5	4.3	3.6	2.8	1.6	0.7	2.0	2.5
Housing and community services	3.5	1.3	1.0	3.3	4.1	1.8	0.5	0.5	1.5	2.9
Culture	0.3	0.0	0.0	0.0	1.9	0.1	0.0	0.0	0.0	1.3
Social sectors	**21.8**	**28.2**	**12.9**	**24.0**	**26.3**	**11.5**	**11.5**	**6.0**	**11.1**	**18.5**

Source: SIGFE, MINFIN, IMF, 2002 – Government of Angola/WHO, UNICEF, UNDP, IOM, Public Financing of the Social Sectors in Angola, 2002.

Despite the recovery of the oil price the following year, expenditures remained at a low level in 1999 due to the resumption of the war. However, the increase in oil revenue, which reached a historical high in 2000, and the greater budgetary priority given to the social sectors brought about substantial increases in expenditure in these sectors in 2000 and 2001. These trends were evident in both education and health. Table 4 indicates the large-scale extra-budgetary expenditure, although there was some decline in 2001.

Table 4: **Executed social sector, 1997-2001** (by functions, excluding debt amortization)

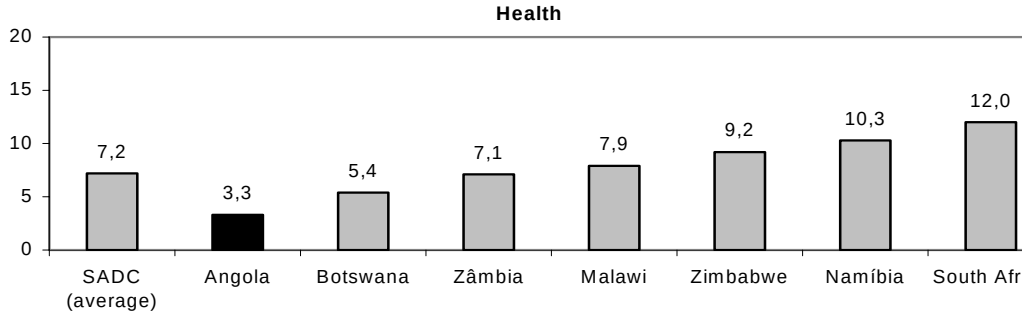
	Expenditure (US $ million)					Expenditure per capita (US $)				
	1997	**1998**	**1999**	**2000**	**2001**	**1997**	**1998**	**1999**	**2000**	**2001**
Education	168	131	142	222	281		10.2	10.7	16.2	19.9
Health	117	70	83	172	238	9.4	5.4	6.3	12.6	16.9
Social security and social welfare	120	36	32	104	111	9.6	2.5	2.4	7.6	7.9
Housing, urban affairs and community services	78	12	21	80	126	6.2	0.9	1.6	5.9	9.0
Culture	6	-	-	-	59	0.4	-	-	-	4.2
Sub-total, social sectors	**489**	**249**	**279**	**579**	**816**	**39**	**19**	**21**	**42**	**57**
Total expenditure (SIGFE data)	**2,242**	**881**	**2,163**	**2,409**	**3,106**	**183**	**70**	**166**	**180**	**225**
Total expenditure (IMF data)	**4,244**	**2,169**	**4,677**	**5,213**	**4,412**	**339**	**168**	**352**	**381**	**313**

Source: SIGFE, MINFIN, IMF, 2002 – Government of Angola/WHO, UNICEF, UNDP, IOM, Public Financing of the Social Sectors in Angola, 2002.

Government expenditure on health during the period from 1997 to 2001 was 3.3% while the average for the SADC countries was 7.2% (see Figure 1). Of the total amount for the health sector, more than 50% was earmarked for secondary level and central units. This policy is partly due to the decline of the primary network and the concentration of professionals in hospitals because of safety reasons. As for major budgetary lines, the staff salaries account for more than 40% of the total, while less than 10% was earmarked for investment. No breakdown is available on spending for acquisition of medicines. The level

of implementation has been very much restricted (between 40 and 55% in 2000) although recent indications suggest an improvement as opposed to the past. Based on other data, indications suggest that the government financial allocation has improved recently: US$ 270 million was budgeted in 2001, which corresponds to around US$ 20 per capita, to which international aid should be added. The concentration of resources in the referral system, which implies major spending, a poor management capacity (also demonstrated by the low budget implementation) and the predominance of emergency programmes (which entail extraordinary measures, however costly), can explain why the funding of the sector is insufficient to meet the needs. However, comparatively this funding is not negligible, but it still does not translate into substantial outputs of the system.

Figure 1: **Percentage share of government expenditure on health in SADC countries, 1997–2001**



Source: SIGFE, MINFIN, IMF, 2002 – Government of Angola/WHO, UNICEF, UNDP, IOM, Public Financing of the Social Sectors in Angola, 2002.

2.7 Health sector reforms

Health sector reform has been ongoing, vis-a-visthe decentralization of authority and budget directly from Ministry of Finance to tertiary care hospitals, institutes and provincial hospitals.[37] Since 2001, all managerial and budget responsibility to have been taken away from the Ministry of Health and given directly to the directorates of the hospitals.

Decentralization has created the Provincial Health Directorates which are dependent on the provincial governments. The Provincial Health Director is appointed directly by the provincial governor as the direct supervisor. The health budget allocation is now part of the provincial government budget with no involvement from MOH concerning its elaboration and management. Sector-wide PHC planning and programming are now the full responsibilities of the provincial governments.

2.8 Human resources for health

Regarding human resource development and re-distribution to cover the most remote areas of the country, a review of the policy on the human resources is under way in order to correct the distortions in the staff profile. In the area of training, action has been undertaken in

[37] Decree n.º 27/00 on 'Paradigma de Regulamento dos Governos das Províncias e das Administrações dos Municípios e das Comunas'.

the last year to put in place operations for the Human Resources Development Plan 1997–2007. The main components under study and elaboration are:

(a) the rationalization of the training system[38] namely, referring to the network of educational institutions that are to enhance teaching-learning quality according to the health framework;

(b) continuous or in-service training[39] through the definition of a strategy for professional development of the staff at the Ministry of Health;

(c) management training.[40]

2.9 Challenges: Key health policy issues and current prospects

The health sector's capacity to respond to needs and demands for services has been fairly limited. Many factors limit the government's ability to develop health policies tailored to needs and in keeping with the resources available as well as the capacity to implement them. Competition with the other sectors, mainly Defence, has left insufficient resources for health. Limited external aid resources, the fragmented system as well as the lack of effective coordination mechanisms are also responsible. The political and military instability, destruction of health units, the inadequate management capacity (mainly at the peripheral level) and concentration of health professionals in the main provincial capitals (Luanda in particular) are compelling factors responsible for the weakness of the health system. Low wages and high living costs demotivate health professionals, and this is reflected in the lack of staff at peripheral level and low quality of health care delivery. On the other hand, a very small portion of the population who are economically better off can afford health care in private clinics in main urban areas. Other private clinics have rapidly expanded in the suburban areas providing care of questionable quality which has never been assessed. All of this has afforded limited access to a large portion of the population.

Based on factors stated above, it is indeed possible to identify the main challenges and new opportunities for the health sector in the context of peace. These factors call for an immediate expansion of services in order to cope with the health needs of the people who have become suddenly more accessible.

2.9.1 Health system analysis

System analysis, policy and health economics are very much needed in this phase of health reform and the redesign of the system. It will also be essential to use the expertise of countries that have gone through similar rehabilitation and reconstruction to accelerate change. External aid is most likely to play an important role in complementing the efforts of the country. It is therefore necessary to involve partners in the process of defining priorities and implementation modalities in order to further avoid the worsening of the current fragmentation and enhance efficiency in the use of resources. New coordination modalities and management instruments for external aid could result in more efficient allocation and utilization of scarce financial resources. Although it is premature to envisage SWAp for Angola, the current fragmentation of aid for poorly coordinated and inefficient projects calls for better streamlining of external funds to complement government funds. From this standpoint, the current conditions and requirements can be assessed to test partial forms of budgetary aid and/or common fund management for

[38] Implementação do "Novo" Sistema de Formação em Saúde, draft, MOH, March 2002.
[39] Estratégia do Programa de Formação Permanente, MOH, February 2002.
[40] Consultoria sobre Formação em Gestão, MOH, September 2001.

some budgetary lines which, along with the building management capacity, can also contribute to the readjustment of current imbalances in the decentralization process.

2.9.2 Scaling up interventions and services

Scaling up and expansion of interventions and a minimum package of preventive and curative services should be provided to the whole population as a minimum standard. Efficient coordination of additional resources will guide partners and new players towards areas of greater need, using common health policies and standards. The situation analysis along with monitoring and evaluation instruments will ensure standards, efficiency and greater impact.

2.9.3 Rebuilding health networks

Rebuilding the health network calls for assessment, re-design and a concerted effort over a long-term period. It is only with plans devised at the provincial level, in keeping with a robust health policy and additional human and financial resources that it will be possible to rebuild a viable health system. Preparatory activities (stocktaking of the network, equipment, transport, personnel, NGOs, etc) in view of reconstruction plans cannot wait, without the risk of agencies implementing projects in areas that are not of priority. Laboratory facilities need to be given priority in order to develop epidemiology and case-management quality assessment standards.

2.9.4 Staff redistribution

Considering the high concentration of medical doctors (MDs), nurses and other health staff in the capital (Table 5), it is necessary to foster the redistribution of staff towards the peripheral areas, using incentives that are being developed by MOH and Ministry of Finance. The new policy together with improved working conditions and security can provide a new organization of health services at the peripheral level. Finding the right balance with local and international NGOs will also ensure better performance and capacity building on long term basis.

Table 5: **Human resources in the health sector, Angola**

Area	**MDs**	**Nurses**	**Others**	**Total**
Luanda	471	4,974	4,094	9,539
Other provinces	185	11,192	4,372	15,749
Total	656	16,166	8,466	25,288

Source: MOH, Human Resource Directorate, Re-conversion of Special Careers – 'Mapa Estatistico' nº5, June 2001.

3. Development Assistance

3.1 General evolution of aid flows into Angola

During the second half of the 1970s and throughout the 1980s, Angola received substantial assistance from the USSR, Cuba and other Eastern bloc countries. Little assistance was received from western countries with the exception of Sweden. The situation changed radically in the early 1990s. In 1990-01, there was a sharp decline in assistance from Soviet allies and closer relations with the major industrial countries, notably the US, which established diplomatic relations with Angola in 1993.

The collapse of the Bicesse Peace Process and the dramatic deterioration of the humanitarian crisis during the war in 1992-94 brought about an increase in humanitarian assistance and expanded presence of international NGOs. In the same period, there was increased UN involvement. Following the Lusaka Protocol of 1994, the donors and implementing partners partially re-oriented their actions towards rehabilitation and recovery, although the instability of the peace process did not allow completion of the shift.

In the Brussels Round Table Donor Conference, jointly organized by GoA, EU and UNDP in 1995, a pledge for 900 million US$ was made in order to implement the Programme of Community Rehabilitation and National Reconciliation. However, this was undermined by ineffective implementation and collapse of the peace process in 1998. Since then, many donors have restricted their donor role to humanitarian activities. Overall, the trend in aid disbursement over the past decade showed an increase in mid 1995 followed by a decline in the late 1990s. According to data from the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD), Angola's net ODA receipts rose from an annual average of US$ 297 million in 1990–93 to US$ 447 million in 1994–1996, and then declined to an average of US$ 359 million in 1997–99. Over the decade, Angola received a total of US$ 3.6 billion, 59% disbursed by bilateral donors and 41% by multilateral donors. The largest bilateral donors in the period 1990-1999 were Sweden, Italy, Spain, USA and Portugal, providing more than US$ 200 million each, while the largest multilateral donors were the EU (US$ 628 million), WFP (US$ 344 million) and World Bank (US$ 219 million).

3.2 External aid in the health sector

In 2000, a study on donor aid flow[41] from EU, the European Commission, Norway and the US showed that 47% of external aid was dedicated to food aid. In the same study, it was demonstrated that health, with 14% of the total gross ODA, was the second sector of importance funded by the donors for a total amount of US$ 43.8 million.

In 2000, external aid for health amounted to 24% of the total public resources for the sector (US$ 182.7 million). Indeed, the donors have substantially complemented the role of the government in some provinces. In the coastal and eastern zones, donors provided approximately one-third of health expenditure, while in the interior zone, they provided almost one-half of the expenditure.[42]

[41] Aid Flows to Angola: An overview, European Commission Delegation in Angola, 2001.

[42] Government of Angola/WHO, UNICEF, UNDP, IOM, Public Financing of the Social Sectors in Angola, Luanda, August 2002.

A more detailed analysis, at the provincial level, reveals that the donor contribution exceeded 50% in seven provinces: Bengo, Bié, Huambo, Kuando Kubando, Kwanza Norte, Malange and Uige. In fact, half of the provinces had more than 40% external financing for the health sector. Aid contributions are shown in Table 6 according to three zones: coastal, interior and eastern. The coastal zone includes the provinces of Bengo, Benguela, Cabinda, Kwanza Sul, Luanda, Namibe and Zaire. The provinces of the Interior are Bié, Cunene, Huambo, Huila, Kwanza Norte, Malange and Uige. The Eastern zone comprises Kuando Kubango, Lunda Norte, Lunda Sul and Moxico. A category in the table called central level was added for expenditure, such as expenditure for MOH, autonomous central institutes and national hospitals. The central level has not been ascribed as a geographical zone due to lack of information.

Table 6: **Government and donor contributions to health, 2000[a]**

Region	Health			
	Expenditure ($ `000)			Donors % of total
	Government	Donors	TotalL	
Coastal	32 660	15 250	47 910	32
Interior	16 639	16 078	32 718	49
Eastern	5 773	3 373	9 146	37
Central Level[b]	83 864	9 145	93 009	10
Total	138 936	43 847	182 783	24

a/ The data for donors are limited to ODA disbursed by Member States of the European Union, European Commission, Norway and the United States.

b/Includes Ministries, autonomous central bodies, health and educational institutions of a national character.

3.3 Partnerships in health programmes

External aid funds are normally channeled through the Ministry of Finance, Ministry of Health, UN agencies and NGOs. The main partners (Table 7) in health are the European Union, USAID, Sweden, the Netherlands, Italy, France, Spain, Portugal, the United Kingdom, Japan, the World Bank and the Agencies of the UN System and the NGO network, both international and national.

Table 7: **Health partners in Angola, November 2002**

Partner	EHA	EPI	HIV	MAL	TB	DSD	HHRR	MPS	TRYP	DES
USA	X	X	X	X		X		X		
CDC Atlanta		X	X							
Italy	X		X	X	X	X				
Spain										
EU	X					X	X			
Sweden	X	X						X		
UK		X								
Norway	X									
Belgium			X						X	
Netherlands	X									
France					X				X	
Portugal	X						X			
UNICEF	X	X	X	X		X		X		
UNFPA	X		X				X	X		
PSI			X	X						
IMF	X	X								
SC-UK	X	X								
OCHA	X									
Oxfam				X						X
MSF	X		X	X						

Source: WHO Angola, November 2001

Direct programme implementation through international NGOs responds to the need of filling the gap concerning availability of adequate technical skills at country level and access to remote or difficult areas. One of the challenges is to increase the sustainability of implementation partners in adherence to national health policy and avoid fragmentation in interventions. There is still a need to secure more involvement from national NGOs and other entities of the civil society in programme implementation.

3.4 Coordination mechanisms and instruments

The recent increase in accessibility to populations previously not targeted (more than a million new beneficiaries) and the existence of vast areas still difficult to access have increased the need to make coordination mechanisms a top priority. The Ministry of Health has faced some difficulties since decentralization and is, therefore, left without a clear definition of principle and methods by which to follow national guidelines. There is also lack of understanding of the accepted guiding role of the MOH on the part of many international players. Competition between partners in terms of leadership and visibility further hamper the MOH in playing an effective coordinating role.

In terms of culture, there is a need for increased experimentation and methods of analysing and deciding on health matters which encompass all participating partners. Only recently, with the development of the Inter-Agency Coordination Committee (ICC) of the Polio Eradication Initiative and the Country Cooperation Mechanism (CCM) for the application of the Global Fund (GFAHMT), the country is experimenting with active involvement of many partners to coordinate various working mordabilities. The absence of a government policy for coordination and the lack of an approved National Health Development Plan discussed with partners in health (though a preliminary draft document prepared by MOH with assistance from WHO and EU) are some of the main challenges and strategic priorities that will be relevant to the role of WHO in coming years. These instruments are needed in order

to create the necessary platform to strengthen and further complement and develop the Basic Law on the National Health System.[43] The decentralization process and creation of Provincial Health Directorates as independent budgetary units will seriously contribute to the Poverty Alleviation Strategy.[44]

There are some coordination mechanisms in place. As regards humanitarian operations, the Ministry of Social Reintegration (MINARS) deals with the coordination through the Humanitarian Coordination Group (HCG) including OCHA, WHO, UNFPA, UNICEF, UNDP, WFP, bilateral agencies and NGOs. Furthermore, the government has set up the Aid Coordination Technical Unit[45] charged with receiving and coordinating humanitarian aid granted to Angola. This Unit is in MINARS and provides mainly administrative support to NGOs. The Humanitarian Sub-Group for Health and Nutrition, chaired by the Ministry of Health, includes members from Ministry of Education, Ministry of Administration and Territory, Health Services of the Angolan Armed Forces, UNICEF, OCHA, some donors and some international and local NGOs. WHO has a specific role of technical facilitator.

Within the management structure of the UN, a group of Heads of Agencies exists although it has not been very active since 2001. Led by OCHA, the Technical Group (formed of UN and NGOs) mainly has the task of coordinating an effective response to humanitarian crises. Another specific group of UN and NGOs in charge of health and nutrition issues based on humanitarian needs has been operating for a number of years under the leadership of WHO and UNICEF. The group was very active during the Consolidated Appeal Processes (CAP) in the period 2000–2002, engaging also in the mid-term review of each of the last three years and monitoring project implementation in health by NGOs. This group has expanded since July 2002 when a specific "block for public health" was formed under the leadership of WHO in conjunction with subcomponents for nutrition, water and sanitation led by UNICEF. This mechanism coordinates with MOH, collecting data on public health needs, players involved, projects and impact.

To support the UN Agencies, but integrating GoA, an inter-agency group has been formed, namely, the Thematic Group (TG) on HIV/AIDS. The TG brings together delegates from a number of Ministries of GoA, UN, NGOs and PLWHA to create a strategic platform for addressing the fight against HIV/AIDS in Angola.

With the aim of reducing infant and maternal mortality, specific coordinating structures and national networks are pursuing specific health themes in malaria, tuberculosis, reproductive health and Integrated Management of Childhood Illnesses (IMCI). This is known as Coordination of Paediatric Services in Luanda. Other coordinating structures, not specifically for health but dealing also with health-related subjects have been created among both national and international NGOs. The Committee of International NGOs (around 80) is called CONGA; the committee for NGOs in Angola and the body for the national NGOs is called FONGA, Forum for NGOs in Angola. The executive body of CONGA is the Liaison Group, formed of 18 NGOs and the President. Both structures are appointed on rotation.

In October 2002, the Council of Ministries approved a constitution of the National Commission for AIDS and Endemic Diseases under the leadership of the PR. The Commission has organs at the provincial level led by governors and a Technical Committee at the ministerial level. Besides the UN Country Team (UNCT) formed by the Head of the UN Agences, other mechanisms exist for donor coordination. At national level, coordination frameworks have been temporarily organized by GoA regarding the Interim-PRSP.

[43] 'Lei de bases do Sistema Nacional de Saúde', August 1992, Decrees 39/83 e 2/85.
[44] Interim Poverty Reduction Strategy, 2001-2003, Ministry of Planning, February 2001.
[45] Decreto nº 3/91 de 19 de janeiro de 1991.

4. Current WHO Country Programme

Angola was admitted as a Member State of WHO on 15 May 1976. In 1990, an international Resident Representative was appointed with official agreement from GoA to lead the Representative Office of the World Health Organization in Luanda.

The WHO Angola Country Office faces the challenge of an operation with, in October 2002, 105 staff in the field and a budget of US$ 20 million for the biennium 2002–03. There is need to use partners, in particular NGOs, to implement, together with the MOH, structures for meeting the expected targets. Following the situation analysis and priority strategies, this document endeavours to propose adjustments from an administrative and operational point of view. This will keep the WHO Angola Office at the service of the country, without duplicating MOH and partner actions, and concurrently strive to create the required environment for effective impact in terms of morbidity and mortality reduction in the country.

4.1 WHO key areas of work and country budget

The Programme budget for 2002–2003, including pledges made until November 2002, provides financial resources for the selected areas as shown in Table 8. These resources are partially implemented directly by WHO, MOH or NGOs.

Table 8: **Areas of work and budget, WHO/Angola, 2002–2003 (US$)**

Programme	Pledged Budget
Country Office Operation (COO)	1,254,000
Immunization and Vaccination (incl. Polio) (IVD)	11,000,000
Emergency, Preparedness and Response (EHA)	4,280,000
Malaria (MAL)	2,500,000
HIV/AIDS (HIV)	970,000
Tuberculosis (TUB)	250,000
Communicable Disease, Prev., Erad., Control incl. Leprosy and IMCI (CPC)	1,070,000
Sustainable Development (HSD)	300,000
Organization of Health Services (OSD)	490,000
Health Promotion and Mental Health (HPR)	180,000
Making Pregnancy Safer (MPS)	400,000
TOTAL PLEDGED BUDGET	22,694,000

Source: WHO Angola, November 2002.

Note: The Budget 2002–03 contains pledges until 31 October 2002. Therefore, it does not include resources involved for emergency and humanitarian action for the year 2003. It also does not include the resources from HQ or AFRO to cover technical support to the WCO. It does not include the cost of eight international staff and 40 national staff paid by contributions to the Polio Eradication Initiative directly managed at HQ.

Evolution of the regular budget resources committed to the WHO Country Office in Angola has shown a modest increase from US$ 2,295,000 in the biennium 1998–99, to US$ 2,752,000 in 2000–01 and to US$ 3,400,000 for the biennium 2002–03. The extra-budgetary fund rose from an average of US$ 1 million per year until 1999 to nearly US$ 10 million in the year 2002. Despite the rapid increase of budgetary resources, the absorption rate of WHO Angola also has rapidly increased in the last two years, from 20% of the planned budget in the first half of 2000 to 90% in 2002.

4.2 Focus of partners and main donors

The increase and rapid acceleration of resources pledged and transferred can be viewed as a logical consequence of the Global Polio Eradication Initiative which recognizes Angola as one of the most challenging countries still to achieve World Polio Free Certification status (50% of extra-budgetary funds are from the polio budget). It is acknowledged that donors trust the Organization and are committed to further support because of the successful achievements to date.

The main donors contributing funds to WHO Angola over the last three years are USAID, CDC Atlanta, UK, Rotary International, the Netherlands for polio eradication; USAID for malaria; Sweden, Norway, UK and Italy for humanitarian action; Italy and CDC Atlanta for HIV/AIDS and Belgium for trypanosomiasis. These areas of focus have also accounted for extra-budgetary funds needed in Angola during the years 2000–2002.

4.3 The WHO sub-offices and distribution of staff

It has been a generally accepted view between WHO and MOH to use the Polio Programme (with a budget 50% of the overall budget) as an entry point for public health. The efforts pointed, in particular, to Integrated Disease Surveillance.

In the last two years, WHO has had to restructure its operations in 17 provinces of the country. There are currently technical staff in 18 provincial sub-offices. The main objective is to assist the provincial government in Integrated Disease Surveillance. This physical presence within the facility of the Provincial Health Directorate enables full coordination with the different structures and functions. In addition, this ensures that there is no duplication of systems during implementation. Six of these offices have highly qualified, competent and experienced staff in public health who render additional supervisory and monitoring services to bordering provinces.

WHO has maintained its role as a technical advisory body at provincial level in order to assist the provincial government in health. The Organization consistently provides support in planning, organization of health services, surveillance, supervision and evaluation. This joint effort has enhanced WHO understanding of the health sector to better identify the critical factors for improving health conditions in Angola. Funds are generally budgeted and processed through WHO/Geneva and channelled to WHO/Angola through WHO/AFRO.

4.4 Staff recruitment

In the year 2000, the WHO Country Office in Angola had a total of 17 staff, of which seven were professional (two international) and ten support staff. By November 2002, the Country Office had increased to 102, including 76 technical staff and 26 support staff (mainly administrative clerks, logisticians, secretaries and drivers). Out of the 76 technical staff, 15 are international and 61 national (see Table 9).

Table 9: **Distribution of technical staff by programmes WHO Angola**

Programme	Total	International
Country Office Operation (COO)	2	2
Immunization and Vaccination (Polio) (IVD)	34	10
Emergency, Preparedness and Response (EHA)	12	2
Malaria (MAL)	5	1
HIV/AIDS (HIV)	2	-
Tuberculosis (TUB)	1	-
Communicable Disease, Prev., Erad., Control incl. Leprosy and IMCI (CPC)	2	-
Sustainable Development (HSD)	1	-
Organization of Health Services (OSD)	1	-
Health Promotion and Mental Health (HPR)	1	-
Safe Motherhood (SM)	-	-
TOTAL TECHNICAL STAFF	**77**	**15**

Source**:** WHO Angola, November 2002.

4.5 The role of the AFRO office and HQ

In order to develop collaborative programmes for the health sector, technical missions from AFRO and HQ are planned by WCO in agreement with MOH. These missions assist the country with situation analyses, data collecting, guidelines, norms and implementation of specific technical health programmes. These missions help the WCO and Member State keep focus on the priorities for the region, allow sharing of lessons learned among countries in the various technical fields; they are instrumental to the elaboration of national strategies, insuring the proper technical back-up to the country.

4.6 Strengths, problems and perspectives

The strengths of the technical cooperation between WHO and Angola are summarized here. The good existing partnerships formed with GoA, civil society and partners in general have given WCO a solid understanding of the political, social, health and humanitarian dynamics of Angola. This forms the basis to define and develop a strategic framework for the health sector. WCO, through its focus on definition, monitoring and reform of the health policy in the last five years has laid the foundations for development in humanitarian assistance and sustainable strategy guidelines. With a combination of a good management system, increased access to information, partnerships in health, investment in advocacy to accelerate mobilization of technical and financial resources, the critical beneficial factors are to secure success in the reconstruction of the country, focusing on its long-term development. The decentralization of the WHO Country Office from the capital to the 18 provinces has created a strong fieldwork presence and allows for better understanding of the problems in the field, greater efficiency in supporting the country through the Provincial Health Directorates and quality results of health programmes with partners. The presence at HQs and AFRO level of back-up technical and support programs and staff will sustain achievement of positive results.

Various weaknesses have been identified. Restricted access to the areas of resettlement have delayed the provision of the Minimum Health Care Package and affected infant and maternal mortality rates. An outreach Plan of Action (POA) in partnership with all relevant players is necessary to cover the vast country, especially the most remote areas.

The lack of a clearly planned and organized approach can result in missed opportunities for strengthening the Angolan health system. Better use of technical backup from AFRO and HQ should be considered to ensure integration of initiatives.

The transledge of WCO staff concerning WHO global and regional programmes and strategies needs to improve. A new pro-active culture for WCO staff needs to be sustained through guided, focused training on WHO corporatie strategies, core functions and programmatic content of work. This will allow for a more organized and systematic routine implementation of programmes.

Decentralization to sub-offices has occurred with slow or no implementation of consistent administrative mechanisms (creation of imprest accounts and other tools for resource management) and operational means (radio, email, vehicles, etc). Therefore, appropriate administrative set-up needs to be considered and secured to sustain an operation with new features, structure and staff distribution at the country level.

Lack of continuity in staff presence due to contract breaks of several months hampers achievements. Management of contracts and resources for extension of staff contract must ensure continuity of actions. At the same time, the imbalance between the number of technical and general staff (currently four to one) obliges the technical staff to carry out secretarial and logistic duties that are normally assigned to general support staff. This creates inefficiency in the technical work. More general support staff is to be recruited to balance technical staff and adequately support operational activities. Lack of general support staff, especially for administration and logistics, hampers a complete and proper analysis of financial documents and control of operations concerning storage, transport, maintenance, distribution of goods and inventory. In summary, decentralization and increased financial resources will strengthen operations. An increase in the number of general service staff, training sessions focusing on operational procedures, larger office facilities, better equipment and maintenance of equipment must be considered with the urgency they deserve.

Despite the above-mentioned weaknesses, it is evident that WHO in Angola has been able to redefine its role while strengthening partnerships with the MOH and stakeholders in the health sector. In addition, the AFRO and HQ have been very supportive of the new role of WCO which is moving towards more health policy development and fieldwork. This has led to a more effective budget implementation rate (around 80% of the total funds available).

5. WHO Corporate Policy Framework: Global and Regional Directions

WHO has been - and is still - undergoing changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges. This organizational change process has, as its broad frame, the WHO Corporate Strategy.[46]

5.1 Goal and mission

The mission of WHO remains "the attainment by all peoples of the highest possible level of health" (Article 1 of WHO Constitution). The Corporate Strategy and the Policy Framework for Technical Cooperation with Member Countries of the African Region outline key features through which WHO intends to make the greatest possible contribution to health in the world, and indeed in the African Region. The Organization aims at strengthening its technical, intellectual and policy leadership in health matters, as well as its management capacity to address the needs of Member States.

5.2 New emphases[46]

The WHO Corporate Strategy emphasizes the following WHO responses to the changing global environment:

(a) adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;

(b) playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;

(c) triggering more effective action to improve health and to reduce inequities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;

(d) creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

5.3 Strategic directions[46]

On the basis of these new emphases, WHO has set out four strategic directions for its contribution to building healthy populations and combating ill-health. These strategic directions, which are interrelated, provide a broad framework for the technical work of the Secretariat:

(a) reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;

(b) promoting healthy lifestyles and reducing risk factors to populations;

(c) developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands, and are financially fair;

(d) developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

[46] WHO EB105/3. A Corporate Strategy for the WHO Secretariat.

5.4 Core functions[46]

The typology of WHO core functions, presented below, is based on the comparative advantage of the Organization at all its levels:

(a) articulating consistent, ethical and evidence-based policy and advocacy positions;

(b) managing information, assessing trends and comparing performance of health systems; setting the agenda for and stimulating research and development;

(c) catalysing change through technical and policy support in ways that stimulate action and help to build sustainable national capacity in the health sector;

(d) negotiating and sustaining national and global partnerships;

(e) setting, validating, monitoring and pursuing proper implementation of norms and standards;

(f) stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health-care management and service delivery.

5.5 Global and regional priorities[47]

In order to be more effective and efficient in its interventions, the Organization has selected a limited number of global priorities on which to focus over the four-year period (2002-2005). The global priorities selected on the basis of those criteria are: malaria, HIV/AIDS and TB; noncommunicable diseases (cancer, cardiovascular diseases and diabetes); tobacco; maternal health; food safety; mental health; safe blood; and health systems.

The WHO African Region[48] is facing enormous health challenges in relation to health. The WHO Regional Office for Africa has decided to focus its attention on 12 priorities closely related to the 11 global priorities, but adapted to the regional context. These 12 priorities are: HIV/AIDS; tuberculosis; malaria; maternal health; child and adolescent health; strengthening of health systems; blood safety; humanitarian and emergency action; health promotion; noncommunicable diseases control including mental health; and poverty and health.

5.6 Making WHO more effective at country level

The expression of WHO Corporate Strategy at country level will vary from country to country. Taking into consideration country-specific health and development challenges, the involvement of other external partners, WHO's current work in and with the country, and the global and regional policy frameworks, WHO will look at getting the balance right between its key functions at the country level. This means the Organization will act more as an adviser, a broker and a catalyst and will involve itself in routine implementation in case of specific, clearly identified initiatives, with a time-limited perspective. A working typology of WHO functions at country level has been developed based on the broader core functions presented above.

[47] WHO: General Programme of Work 2002–2005.

[48] The work of WHO in the African Region, Strategic Framework 2002–2005.

The specific functions at country level are:

(a) supporting routine long-term implementation;

(b) catalysing adoption of technical strategies and innovations; country-specific adaptation of guidelines; and seeding large-scale implementation;

(c) supporting research and development; policy experimentation; development of guidelines; stimulating monitoring of health sector performance; and trends assessment and anticipation;

(d) sharing information; generic policy options and positions; guidelines and standards; case studies of good practice; and advocacy;

(e) providing specific high-level policy and technical advice; serving as broker and arbiter; exercising influence on policy, action and spendings of government and development partners.

6. Strategic Agenda: Main Selected Strategies

6.1 Strengthen national health system

(a) Facilitate elaboration and diffusion of a National Policy and a National Strategic Plan on the health sector through inclusive articulation with national and international partners operating in health.

The CCS exercise is aimed at restructuring and assisting MOH with a system of tools in creating health policies, planning and monitoring. The wealth of experience gained by all stakeholders of the health sector, during recent years in Angola, will be beneficial to the preparation of national policies and strategies during the current transitional phase of the country.

WHO is seen by many partners as a neutral, technical "super parties" entity. It plays a catalytic role in order to facilitate dialogue amongst all partners of the health sector. In addition to being the chairing body of the process, MOH is also the operational unit tasked to ensure full coordination amongst all partners.

(b) Steer MOH towards effective stewardship. Support an inclusive methodology to analyse health issues with partners. Create an open space for dialogue in the respect of the national right to decide on its own health policy.

In this transitional phase, effective state stewardship can be achieved only if a clear commitment from the country exists and if a clear attitude is harnessed towards building a real partnership. At the same time, in a phase of multiplication of efforts (given the increased available financial resources typical of the post-conflict), partners in health should be brought together from inception for collaborative ideas in the health sector.

A key component for strengthening national stewardship is the availability of national experts within the MOH capable of managing and monitoring the priority issues related to the health of the Angolan population. The national health system needs to be assessed and re-designed according to the new demographic characteristics of the country. The Minimum Health Care Package is to be universally provided and monitored to increase its coverage according to available resources.

During this phase, where MOH has to regain ownership of the health sector, WHO will help consolidate a clear sense of direction through elaboration and diffusion of standards and norms related to the health system. WHO will assist the MOH to negotiate with partners in order to critically analyse present strategies and actions, and find the way forward. MOH experts will analyse and address the current situation in the health sector using the following criteria: feasibility, relevance, efficiency, coverage, vulnerability and sustainability.

In coordination with other partners, WHO will examine the lessons learned from the other countries which are developing or coming out of a prolonged conflict. Key challenges are macro health analysis and planning. At the same time, hospital management based on performance-related indicators must be considered in order to improve the referral system and provide the specialized treatment needed for high tech health diseases.

(c) Help the country recover from a long civil war, through transition to long-term development.

Through more than 30 years of war, the health system has diminished with a great gap in distribution and health staff at peripheral level. Since the Memorandum of Understanding of Luena in April 2002 and the stoppage of hostility, it is now possible to concentrate on securing better access for the Angolan population to primary health care services.

The onus on the health system, for the population in the recovery phase, deals primarily with better case management (diagnosis and treatment of diseases) for the segment of the population which is highly vulnerable and suffering from acute malnutrition, malaria, and parasitosis. Pregnant women and unvaccinated children of the population recently displaced or coming from the former UNITA held municipalities are a special focus during the first months of transition.

Providing essential care to these vulnerable groups in this first phase of the post-conflict era and the reintegration of the former UNITA health staff will be highly instrumental to peace building and stabilization. Strengthening of the heath sector will be achieved through different resources and interventions, including the disease control programmes, although it is considered that the most important WHO role in the transitional phase is to assist MOH in its leadership role in the health sector.

The improved access to PHC services will take into account the real needs of different populations co-existing in Angola during the post-conflict period. Response should be designed and implemented as population-specific because of the different environments within which they strive to survive. Three population groups need to be considered: new populations in the previously UNITA-held areas, returning and resettling populations (with special attention to IDPs and refugees) and “stable” populations. The areas previously held by UNITA lack basic social services and need health staff to be re-trained and reintegrated in the National Health System. WHO will look into the technical issues that might facilitate sûch integration. Resettlement areas will also need a transition health network to ensure basic services until a long-term system is in place. As a challenge and in order to better ensure that returnees quickly encounter a response to their basic needs, the health services and network need to be available before people move into their areas of origin. Resident populations are suffering from a number of constraints: lack of staff, equipment and training; poor management; non operational referral system.

WHO will implement major strategies in the transition phase in accordance with key issues. A data base of needs based on technical assessments will be organized and assisted by WHO at both provincial and national levels of MOH, in order to secure the follow-up of the emergency needs of IDPs and new populations during resettlement. In partnership with relevant entities, a minimum health care package will be implemented for IDPs, returnees and newly accessible populations. Assessment of the

health system (facilities, management issues, medical equipment, supplies, human resources, financial system) will enhance the capability of MOH in the design and reconstruction of the national health system. Re-integration and training of health professionals from the formerly UNITA held areas will contribute to stabilization and peace.

(d) Strengthen institutions at the provincial level

Provincial Health Directorates will be strengthened in the management of key health issues. The decentralization process in Angola has not been completed yet and the Provincial Health Directorates are not yet independent budget units.[49] For this reason, the health plans might change according to the priorities set at the Governor's Office where budget allocation for the health system takes place.

Through its WCO in Luanda and the sub-offices at the provincial level, WHO will:

(i) collect, analyse and share information, using operations research (OR), to create better evidence for the decision making process regarding integrated epidemiological surveillance, performance-related indicators and KAP studies;

(ii) build capacity at the Provincial Health Directorates in priority setting, planning, monitoring and evaluation using OR for quality control;

(iii) create mechanisms for sound supervision and monitoring with focus on integration and accelerating programme implementation;

(iv) assist MOH and partners in the process of human health resources distribution, focusing on definition of elements to better place health professionals at the provincial levels;

(v) assist partners in situation analysis and planning interventions, always interlinking actions with MOH at central and provincial levels;

(vi) implement and train on OR at the provincial level in order to better understand results and impact, and accordingly re-orient operational strategies.

(e) Use an integrated system approach

Qualitative PHC, efficiency and sustainability will be better achieved through integration of health programmes. A participative analysis of the needs of the population and the available resources in the country will assist in defining the minimum health care package. Non-medical perspectives are to be considered in order to complement the curative dimension of the health system with emphasis on promotion and prevention so as to create a real impact in the health determinants concerned with good health and well-being, starting from the most vulnerable people. WHO will assist MOH in the integration of programmes for polio eradication, malaria, HIV/AIDS, TB, leprosy and emergency control.

(f) Assist MOH in monitoring implementation of norms, standards and plans

[49] Government of Angola/WHO/UNDP/UNICEF/IOM, Public Financing of the Social Sectors in Angola, 2002.

One of the most challenging concerns in Angola is to monitor application of norms and standards and implement decisions and plans. WHO will prioritize with MOH in these areas of need and jointly elaborate on the instruments and mechanisms for monitoring.

6.2 Implement priority programmes

(a) Use health as a bottom-up tool for poverty reduction strategies

Taking into account the extraordinary features of the transition of the country towards long-term development, special emphasis will be given by WHO on creating evidence on what policies, strategies and interventions in the health sector can ensure better impact in poverty reduction in Angola. The beneficiary population is to be involved at community level.

On the basis of regional recommendations, WHO will support, through local NGOs, the development of integrated micro-projects in the community, including education, water and sanitation, medical supplies, micro-credit, etc. Such initiatives can also be used to quantify cost-impact and to draw lessons so as to replicate them on a wider scale when successful.

(b) Mainstream special area health programmes

Education, gender, care of IDPs and returnees and the fight against HIV/AIDS are considered by WHO as special areas. MOH will work in close collaboration with other partner agencies, especially UNICEF and UNFPA, to promote risk-free behaviour in sexual practices, while combating discrimination against PLWHA and violence towards women.

IDPs, resettled and returnees are priority groups to be targeted in the health sector analysis and response. Relevant questions address minimum care packages and increased access to PHC, including vaccination, for IDPs. The fight against HIV/AIDS in a country where HIV infection has increased almost three fold in two years is of great concern and has become an issue in every action related to health. It is evident that education, gender, IDPs and HIV/AIDS are closely interlinked. WHO will spearhead policies and actions addressing them, placing special focus on the linkage.

(c) The Priority Technical Areas selected by WHO for the Period 2002–2005

The above-strategies will be powerful strategic directions through which the following priority technical areas selected for the period 2002-05 will be implemented:

(i) ***Health Systems Development:*** The health reform will include the National Health policy and strategies; the financial system and its performance, management mechanisms and indicators; the organization of health services (national health network, referral system, minimum health care package, nutrition package); essential medicines and equipment, including protocols, distribution and monitoring system (ARV, etc); the Health Information System, including integrated disease surveillance; the Human Resources Development Plan (new and in-service training, integration of former UNITA health staff and re-distribution of staff by province and central levels).

(ii) ***Communicable Disease Prevention and Control:*** One of the main challenges in Angola will be to sustain and strengthen the EPI Programme, including the Polio Eradication

Initiative and Measles Control; the HIV/AIDS Control Programme; the Roll Back Malaria Movement; TB Control with implementation of the DOTs strategy in the 18 provinces; the Leprosy Elimination Programme; extension of the IMCI strategy to all provinces; the Trypanosomiasis Programme; the Onchocerciasis Control Programme; Schistosomiasis Control.

(iii) ***Reproductive Health:*** In reproductive health, the Making Pregnancy Safer Initiative will be gradually extended to all provinces of the country.

(iv) ***Emergency and Humanitarian Action:*** Basic elements of humanitarian action will be the stabilization of populations during the process of return and resettling. Technical components will be: the implementation of a database at provincial and national levels as a tool for preparedness and response to epidemics; the provision of a Minimum Health and Nutrition Care Package; the reintegration of the former UNITA health staff into the National Health System; and the fight against HIV/AIDS where the process of return and resettlement of displaced people and refugees occurs. Water Quality Control activities will be implemented according to available resources in the resettlement sites.

(v) ***Health Promotion:*** Health Promotion with advocacy and integration of health programmes at provincial level together with Environmental Health and Sustainable Development activities will be carried out. The Africa 2000 Initiative, Healthy Cities; disposal of hospital waste; and community-based initiatives are the specific components of the WHO endeavour.

6.3 Partnership and resource mobilization

(a) Empower civil society to advocate with government and international partners

Civil society in Angola needs to be empowered in order to become a real player in the negotiation process concerning health directions in the country. Seed money and technical tools will help build experience and capacities in groups such as the Faculty of Medicine of the Agostinho Neto University (ANU), churches, national NGOs and associations, private enterprises. This strategy will ensure that some groups in the civil society become real interlocutors of the GoA in updating national strategies for health. One issue which needs attention is capacity building in strategic planning, starting from the situation analysis.

Given the great productivity of the country in terms of oil, diamonds and wood, the private sector is widening its scope of action, including community health amongst its targets. WHO will assist GoA in advocating with the private sector, recognizing the already existing potential, both in terms of financing experiences and technical actions towards community health and better access to provision of health services.

(b) Form partnerships with donors and recognize areas of comparative advantage

The current commitments and plans from the donor community are known, understood and shared among all partners under the leadership of MOH. WHO will assist, together with other agencies, to better promote a shared assessment of the map of donor efforts. Furthermore, WHO will analyze with donors the national sectoral policies and strategies in order to recognize how each partner or alliance of partners can better help GoA implement actions towards planned goals and objectives in the sector.

Synergies among GoA, bilaterals, multi-laterals and NGOs which consolidate the vision for better health are sought within the scope and strategies selected from GoA and MOH. One question to be

addressed by WHO in Angola in the next years should be: Which players and criteria will better help create the new Angolan health system in accordance with GoA?

Interest from donors can be harmonized in order to get a better understanding of the situation, hence facilitating an allocation of financial and technical resources to priorities. Space for dialogue is facilitated between the donors and the GoA by WHO, ensuring presence of a third party: the civil society.

(c) Use of a multi-sectoral approach

In this transition period, a comprehensive health strategy can only be achieved in concurrence with the ministries which directly or indirectly support actions concerning the health sector. These include the Ministry of Finance, of Planning, of Woman and Family; of Culture and Education; of Sports and Youth; of Social Reintegration; the Ministry of Territory and Administration. Specifically with the Ministry of Finance, advocacy and studies are needed on the implication of better health with proposed scenarios for different investments in health and the preparation of the indicators to measure performance of the health system at its three levels. These tasks will need to be performed in conjunction with and on the basis of understanding which strategies make greater impact on the health of the population. In this respect, a study carried out in Angola, with assistance from WHO, can contribute to the financial strategic directions for the health sector.

7. Strategic Agenda Implications for WHO

7.1 Organizational implications

(a) better coordination and integration between the various areas of work at WCO together with clear delegation of authority for decision-making and administration to the Heads of Technical Areas at country level (CO);

(b) greater decentralization in the planning and use of resources from WCO central office in Luanda towards the sub-offices at provincial level so as to ensure greater flexibility and timely response to local needs (CO);

(c) greater integration and coordination among the three levels of the Organization with clear definition of responsibilities between HQ and AFRO. Technical missions from the two levels are always to be coordinated with WCO ensuring strict priorities identified by GoA and advanced planning to ensure quality outputs. (CO, AFRO, HQ);

(d) taking into account the increased need of timely implementation, greater delegation of authority is vital to the WR (AFRO and HQs);

(e) given the volume of activities required, there is a need of strengthening the administrative department at WCO in order to secure accountability and good administration in general;

(f) given the size of the operation, a post of Head of Programme Operation, to act as Deputy WR, should be created (CO and AFRO);

(g) there is need for increased Technical Support to the country, through creation of international posts and maintaining the short technical missions on the selected priorities, focusing on health policy, planning and information systems (HQ, AFRO);

(h) staff policy needs to be addressed in order to make working for WHO more attractive. By creating new modalities of contract, learning from WHO and other UN agencies, quality of staff would dramatically increase (AFRO and HQ);

(i) improve fundraising strategies at the three levels of the Organization, including creation of mechanisms for transference of EB resources from donors directly to the CO, provided that clear guidelines and norms are in place (CO, AFRO).

7.2 Human resources

(a) there is a need for specialized personnel currently not covered by existing operations (health economics, health policy and planning, engineering for rehabilitation of national health network etc.,);

(b) increase physical presence of WHO staff at the MOH facilities in order to contribute to the building of country institutional capacity (CO);

(c) in-house courses and training activities for WHO staff (HQ, AFRO and CO).

7.3 Financial resources

(a) to provide additional funding, not covered by the Country Budget, will be required in order to meet the challenges of the new context of reconstruction of the country, especially for contracts with partners/NGOs to implement activities (HQ, RO and CO);

(b) to ensure continuity of contracts and success for the decentralization of the technical cooperation at the provincial level, resource mobilization needs to be improved, especially at the country level together with good negotiation with donors concerning operational costs;

(c) to monitor operational costs related to the size of the mission: vehicles, office space and equipment, etc.

8. Conclusion

The Strategic Agenda for the period 2002–2005 is mainly related to strengthening of clear directions with constructive dialogue amongst national and international partners of the health sector.

The challenges of reconstruction and decentralization need to be focused with the following dynamics taken into account: the re-design of the health network; the provision of a basic health package to all population, starting with the most vulnerable; the re-integration of the former UNITA health staff and the threat posed by the exponential increase of the spread of HIV/AIDS shown in WHO/MOH studies.

In order to strengthen the capacity of the Ministry of Health and better respond to the needs of the country at large and of its people according to the priority strategies identified in Chapter 6, it is necessary to improve WHO Country Office delivery capacities. This will enable it to efficiently meet the expectations of the government, partners and people of the country by promoting participation, transparency and accountability for developing the National Health Policy and Strategic Plan.

Implementation of the WHO Cooporation Strategies must focus on health information and partnerships in order to create a baseline for the policy-making process to be achieved. Similarly, it is

necessary to provide a follow-up mechanism on the selected strategies and actions to fully realize the impact of measures undertaken.

There needs to be a shift from a vertical disease oriented approach to a policy and strategy of development approach. This will act as a systematic tool for reconstruction of the social sectors, specifically health, in Angola. Implementation of strategies and decentralization to the provincial sub-offices implies greater delegation of authority at the country level and clear mechanisms to strengthen programme implementation and ensure full accountability.

It is imperative to create conditions for the sustainability of actions supported by WCO, aiming at facilitating the transition from a phase of emergency to one of long-term development. Promoting and strengthening policy and actions aimed at decentralization must involve local people. These initiatives from the health sector must begin with the historically disadvantaged groups. In light of these observations, WHO has identified partners at various levels to be brought into the strategic vision, and in combination, secure the success of this plan. The challenge to maximize on joint synergies and implementation of health policies and services must be achieved for the well-being of the population of Angola.

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ANNEX 1

LIST OF KEY PARTNERS WHO HAVE CONTRIBUTED TO THE CCS ANGOLA

I. Government of Angola

1. Minister of Health
2. Vice-Minister of Health - Public Health
3. Vice-Minister of Health – Hospitals
4. Secretary General, MoH
5. Chief of the Planning Cabinet, MoH
6. Directors of Programmed, MoH
7. Vice-Minister of Planning
8. Vice-Minister of Education
9. Minister of Family and Gender
10. Liaison for UNDP

II. Government of Luanda Province

1. Governor
2. Vice-Governor for Social Affairs
3. Director of Health
4. Architect

III. Diplomatic Missions

1. Ambassador of Norway
2. Ambassador of Sweden
3. Ambassador of UK
4. Counselor to the Portuguese Embassy
5. USAID, Director of Projects
6. European Union, Health Advisor
7. Italian Cooperation – Embassy of Italy

IV. International Agencies

1. UNICEF, Representative
2. UNFPA, Representative
3. UNDP, Representative and Resident Advisor
4. OCHA, Chief of Unit
5. WFP, Nutritionist
6. WHO, AFRO/TCC
7. WHO, EHA/HQ
8. WHO, AFRO/PPE

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V. NGOs

1. Action Against Hunger
2. ACF
3. AFRICARE
4. CARE International
5. CONCERN
6. COSV
7. GOAL
8. CRC
9. IPMP
10. MDM
11. MSF Holland
12. MSF Switzerland
13. PSI
14. Save the Children

ANNEX 2

PROCESS FOR ELABORATION OF CCS – ANGOLA (PORTUGUESE)
Outline of CCS Meetings – Angola

DATE		ACTIVITY	PARTICIPANTS
Year	**Month**		
2001	April 28 to May 05	Inter-regional orientation meeting on the CCS - Tunisia	HAS/PPE/CLT/WR Angola
	September	28th Regional Program Meeting - Harare: CCS Process Evaluation for countries in Region	DPM/TCC/WHO Representatives: Angola, Burkina Faso, Congo, Ethiopia, Democratic Republic of Congo, Tchad, Zambia
	September 30 to October 07	**First CCS mission** to Angola /AFRO-Geneva	Dr Kadri Tankari – TCC/AFRO/Dr. Alessandro Colombo - EHA.Genebra/Sr. Bernardino Cardoso - PPE/AFRO
	September 30	CCS Mission meeting with technical team in Angola	CCS Mission/WR. Angola/Technical team Angola
	October 1 to 2	Meeting with **MOH** to discuss the principal elements of the CCS process	Dra. Albertina Hamukwaya - Minister of Health and Dr. José Van - Dúnem - Vice-Minister of Health/CCS Mission/WR Angola/Technical team Angola
	October 3 tof 4	Meeting with **Government** officials to discuss the principal elements of the CCS process	Sr. Aníbal Rocha - Governor of Luanda Province, Dr. Simão Paulo -Vice Governor/ Provincial Government Team/Sr. Severino de Morais, Vice – Minister of Planning/MOH Tehcnical team /CCS Mission/WR Angola/ Technical team Angola
	October 3 to 4	Meeting with **Diplomatic Missions** to discuss the principal elements of the CCS process	Embassador from Norway, Sweden, UK/ Advisor to Portuguese Embassador, USAID Program Director/ EU Health Advisor/ CCS Mission/WR Angola/ Technical team Angola
	October 3 to 4	Meeting with **International Organizations** to discuss the principal elements of the CCS process	Country Representative for UNDP, UNFPA, OCHA, UNICEF/CCS Mission/WR Angola/ Technical team Angola
	October 3 to 4	Meeting with **NGOs** to discuss the principal elements of the CCS process	ACF / ICRS / MSF-Holland / MSF – Swiss/ CCS Mission /WR Angola / Technical team Angola
	October 5	Meeting with **MOH** to identify the main challenges e how to improve the cooperation	Minister of Health, Vice-Ministers of Health, National Directors, Program Directors / FAA/ CCS Mission /WR Angola / Technical team Angola

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2 002	**February 20 to 21**	**Regional meeting on CCS – Harare**	
	October 23	Meeting with **MOH** to discuss the results from the 1st CCS Mission	Vice-Ministers of Health, National Directors, Program Directors/CCS Mission/WR Angola/Technical team Angola
	April 20 a 26	**Second CCS Mission** /AFRO-Geneva	Dr Kadri Tankari - TCC/AFRO/ Dr. Alessandro Colombo - EHA.Geneva/Sr. Bernardino Cardoso - PPE/AFRO
	April 23	Meeting and discussion of strategies with **MOH**	Dra. Albertina Hamukwaya - Minister of Health; Dr José Van - Dúnem - Vice-Minister of Health; National Directors, Program Directors/ CCS Mission/WR Angola/Technical team Angola
	April 23	Meeting and discussion of strategies with **Donors**	WHO/Norwegian Embassy/Italian Cooperation/OCHA/ UNDP/UNFP/Portuguese Embassy/CCS Mission/WR Angola/Technical team Angola
	April 24	Meeting and discussion of strategies with **NGOs**	PSI/IPMP/GOAL/CONCERN/Save the Children/ACF/MDM/COSV/CARE International / AFRICARE/ICRC/CCS Mission/WR Angola/Technical team Angola
	May	WHO retreat –CCS discussion with entire country staff	WR Angola / Technical team Angola/Angola Staff
	October 14 to 15	**Adoption and CCS documents revision meeting - Harare**	Representatives for Angola/Ghana / Kenya/Tanzania/MDM/AFRO
	November 19 to 21	WHO retreat – Last draft presented to WHO staff and MOH delegates	Dr Lutumba, Planning Cabinet, WR Angola/Technical team Angola/Angola Staff
	November 29	CCS document submitted to Afro	WR Angola / Technical team Angola
	December 10	Comments & suggestions from Afro	Dr Kadri Tankari - TCC/AFRO/Dr. Alessandro Colombo - EHA.Genebra/Sr. Bernardino Cardoso - PPE/AFRO
	December 10 to February 7	Document revision to include inputs from Afro	WR Angola / Technical team Angola
2003	February 7	Last draft discussion with **MOH**	Minister of Health and Vice-Minister of Health/ WR Angola/Technical team Angola
	February 10	Last draft submitted to Afro	Dr Kadri Tankari - TCC/AFRO / Dr. Alessandro Colombo - EHA.Genebra/Sr. Bernardino Cardoso - PPE/AFRO