

**Providing health services in countries disrupted by civil wars:
a comparative analysis of Mozambique and Angola
1975–2000**

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Disclaimer

The views expressed in this document by named authors are solely the responsibility of those authors.

Note

This study was completed at the beginning of 2001. Afterwards, dramatic events have altered the political situation in Angola, paving the way to a peace settlement, which for the first time seems to stand a chance of succeeding. We sincerely hope that the grim picture of Angola, sketched in this study, is consigned to the past, once and for all.

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Acronyms and abbreviations

AAs	Assembly Areas (demobilization programme in Mozambique)
ADB	African Development Bank
BS	Budget Support
BWI	Bretton Wood Institution
CHAP	Consolidated Humanitarian Assistance Programme
CHW	community health worker
CIS	Commonwealth of Independent States
DFID	Department for International Development (UK)
DHA	Department of Humanitarian Affairs
DPCCN	Direcção de Prevenção e Combate às Calamidades Naturais [<i>Department for the Prevention and Combat of Natural Disasters</i>]
ECHO	European Community Humanitarian Office
ECOMOG	Economic Community of West African States
EDP	Essential Drugs Programme
EU	European Union
FRELIMO	Frente de Libertação de Mozambique [<i>Mozambique Liberation Front</i>]
GDP	Gross Domestic Product
GNP	Gross National Product
GoA	Government of Angola
GoM	Government of Mozambique
GPA	General Peace Agreement
GURN	Government of National Unity and Reconciliation
ICRC	International Committee of Red Cross
IDPs	internally displaced persons
IMF	International Monetary Fund
MCH	mother and child health
MoH	Ministry of Health
MPLA	Movimento Popular de Libertação de Angola [<i>People's Movement for the Liberation of Angola</i>]
MSF	Médecins sans Frontières
NGO	non-governmental organization
NHS	National Health Service
OCHA	Office of the Coordinator for Humanitarian Assistance (UN)
ODA	overseas development assistance
ONUMOZ	UN Operation for Mozambique
OPV/DTP	Oral Poliovirus Vaccine / Diphtheria Tetanus Pertussis Vaccine
PHC	primary health care
PKO	peacekeeping operation
PRE	Programa de Reabilitação Económica [<i>Economic Rehabilitation Programme</i>]
PSS	Projecto do Sector Saúde [<i>Health Sector Project</i>]
QIP	quick impact project
RENAMO	Resistência Nacional Moçambicana [<i>Mozambican National Resistance</i>]
SAP	structural adjustment programme
SDC	Swiss Development Corporation
SRPA	Special Relief Programme for Angola
SEAS	Secretaria de Estado para a Assistência Social [<i>State Secretariat for Social Affairs</i>]
SRSR	Special Representative of the Secretary-General
TBA	traditional birth attendant
UCAH	Unidade de Coordenação da Assistência Humanitária [<i>Humanitarian Assistance Coordination Unit</i>]
UN	United Nations

UNAVEM	UN Angola Verification Mission
UNDP	UN Development Programme
UNDRO	UN Disaster Relief Organization
UNHCR	UN High Commissioner for Refugees
UNICEF	UN Children's Fund
	União Nacional para a Independência Total de Angola [<i>National Union for the Total Independence of Angola</i>]
UNITA	
UNOHAC	UN Office for Humanitarian Assistance Coordination
UNPROFOR	UN Protection Force
UNSCERO	UN Special Coordinator of Emergency Relief Operations
US	United States of America
USAID	US Agency for International Development
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

Executive summary

Introduction and methods

This study aims to: analyse the health sectors of Angola and Mozambique since 1975; explore their contributions to the promotion of peace or mitigation of conflict; compare the roles of the different players, factors and contexts in shaping events in the two health sectors; analyse sector responses to economic crisis, war and disruption; and discuss the challenges posed by post-conflict reconstruction in Mozambique, which could be relevant to Angola and other countries emerging from war.

The study uses a comparative approach to identify common factors, as well as particularities, that have contributed to shaping the contexts of the two countries and the strategies adopted by each health sector. The study draws on the experience of the authors in the two countries, on an extensive bibliographic review, and on interviews of informed persons. For Angola, on which there are fewer written sources, a questionnaire was addressed to academics and practitioners. The study was commissioned by the World Health Organization, Department of Emergency and Humanitarian Action, under the programme Health as a Bridge for Peace, co-funded by Italy and DFID/UK.

Background

Since the end of the Cold War, the international humanitarian system has responded to the challenges arising in the new world climate with profound changes, including the restructuring of its institutional settings, the militarization of the relief system, the political disengagement from non-strategic areas, increased UN responsibilities and the expanded task-sharing of military operations with the intervention of regional forces. Intense debate on mushrooming humanitarian crises has led to new conceptual models which recognize the inadequacy of the traditional paradigm of the “relief to development continuum”. The new models focus on understanding the new conflicts and identifying the origins of complex emergencies in the political economy of marginalized countries and in the new international relationships in the age of globalization.

The use of humanitarian aid as a surrogate to a direct political engagement with non-strategic countries underlies the rise of non-governmental organizations (NGOs), which have become the main aid channel in most war-torn countries, in line with the dominating drive to diminish the role of the state. This shift has reduced the capacity of local institutions and the sustainability of programmes, as witnessed in the two countries under study.

Despite having many features in common at independence in 1975, Angola and Mozambique have since evolved along divergent paths, leading to opposite outcomes: political stability and sustained economic growth in Mozambique, devastation of the economic and social fabric and degraded living conditions in Angola. The analysis of the divergence of the two countries and of their health sectors is the main theme of the study.

Emergency and humanitarian assistance in Angola

Huge economic interests around the country’s rich natural resources, an ethnic divide with ancient historical roots and an irreducible protagonist, Jonas Savimbi, have made unattainable a negotiated settlement of the Angolan chronic crisis. War has become a constant feature of Angolan life, a screen removing from scrutiny the results of poorly conceived and implemented policies. With defence getting the lion’s share of the budget, starved public

services have dramatically contracted and donors have been reluctant to engage with Angola. Aid per capita has oscillated in the range of US\$10–30, a meagre contribution dwarfed by the country's giant mineral revenues. Causes of donor restraint can be identified in poor absorption capacity, the risks of failure in the prevailing environment, limited access and poor security for aid delivery, donor concerns about aid fungibility, government disinterest in mobilizing external aid, troubled relationships with the BWIs and the general disarray of public finances.

Given UNITA's reluctance to let outsiders operate in its territory, relief delivery in these areas is ill documented. Before the Bicesse Accords of 1991, few agencies operated under UNITA's strict control and uncertain security conditions. MSF-F was outspoken in its praise of UNITA health services, without providing evidence for these claims; other respondents argued that this positive perception was based on orchestrated demonstrations of good performance for external consumption.

Before 1994, the under-resourced institutional arrangements put in place by the government and the UN for the coordination of humanitarian assistance met with limited success. The peace process was doomed from the beginning, as the holding of elections was ingenuously seen as a solution to entrenched problems. The third war, started in 1992, caught aid agencies unprepared, as most of them had shifted their relief programmes to rehabilitation and development. The failure of the then peacekeeping operation (UNAVEM II) prompted the UN to authorize a much larger operation after the Lusaka Protocol, signed in 1994. The UN body mandated to co-ordinate humanitarian assistance, UCAH, which was not integrated within UNAVEM, in order to maintain a distance from the latter, won unanimous praise for its performance, at least in its initial phase.

The ceasefire signed in November 1994 ensured a period of relative stability until late 1998, when the country returned to all-out war. Despite the present political and military advantage enjoyed by the government, no durable solutions to the crisis seem available, as huge interests around oil, diamonds and arms make the status quo a convenient cover for further accumulation of wealth. Increasing oil revenues notwithstanding, the government financial position remains precarious, as future production has been mortgaged and the debt service is unbearably high, due to past borrowing at high interest rates.

Emergency and humanitarian assistance in Mozambique

At independence, an undisputed ruling party, FRELIMO proceeded to implement its policies in relative freedom. This offered opportunities to learn from past failures and to adapt policies accordingly. This empirical approach has been a strong feature of the Mozambican recent past. Mozambique has relied upon aid since independence, in the form of import support, capital-intensive development projects and technical assistance provided by socialist countries and solidarity workers. Initially aid was limited, due to the country's non-aligned position and to the government's policy of accepting external support only when found consistent with its programmes.

Gross economic mismanagement, the international economic crisis, South African aggression and disastrous social-control policies led the country to the verge of collapse. The rebel organization, RENAMO, expanded its ruthless activities to affect the whole country, appearing near to outright military victory in 1986, but losing the initiative afterwards, due to the over-extension of its limited capacity. In 1987, a structural adjustment programme conceived by the government and launched without previous IMF approval was introduced,

pleasing Western donors: food aid in 1987 doubled in relation to 1985. In the same year, the government launched the first of a long series of emergency appeals, the success of which demonstrated the popularity of Mozambique's political shift among Westerners.

With the growth of external inflows, aid agencies gained prominence while the government lost control of relief activities. As RENAMO attacks increased, the number of IDPs and refugees grew dramatically, while the lack of security hindered the distribution of relief. The crisis came to be called a "complex emergency", an original term introduced to defuse political sensitivities.

Attempts at reorganizing emergency activities within the UN family, with the establishment of a new emergency unit within UNDP, failed to ensure the compliance of the most powerful agencies and generated dissatisfaction within the government, which advocated the strengthening of existing national structures. If the UNDP coordination role was disputed, some services it rendered to the aid community were valued, such as the preparation of emergency appeals and the gathering and dissemination of information. In many ways these functions became the blueprints for subsequent standard operating procedures, such as the Consolidated Appeal Process.

By 1990, war, drought and economic crisis had made Mozambique the world's poorest and most aid-dependent country. While the government concentrated rural populations in accommodation camps, RENAMO intensified its violent strategy of rural devastation, exhausting the resource basis of its war effort. The war- and drought-induced famine forced the rebels to discuss the opening of humanitarian corridors. RENAMO-controlled areas had received only limited humanitarian assistance (from ICRC), due to the condemnation of the group for its atrocities, its inability to negotiate external assistance, donor refusal to engage outside government structures, and the fear that providing relief in rebel areas might consolidate their position. By attracting populations to areas under its control and strengthening its popularity through the provision of basic services, relief aid enhanced the government position. Even if the consequences of the limited relief provided in RENAMO areas cannot be estimated, when these areas opened up after years of extreme hardship and isolation, their inhabitants were found in appalling conditions.

With hindsight, the Peace Agreement of 1992 appears to have been inevitable. The two rivals were exhausted, no military solution was in sight, international pressure to clinch a deal was mounting, and an extremely severe drought was hitting the region. This explains why the peace process fared surprisingly well, despite the obstacles. The Peace Agreement defined a wide mandate for the UN, including the coordination of humanitarian activities (UNOHAC), integrated within the peacekeeping structure, which reoriented humanitarian activities to include RENAMO-controlled areas. Whereas at central level the UNOHAC's lead was accepted only reluctantly by the most powerful UN agencies, UNOHAC was more successful in its coordination role at field level.

The transition period witnessed the proliferation of NGOs, which expanded their activities to cover new areas, reflecting donor concerns about government capacity and their perception of NGOs as responsive and neutral aid channels. However, NGOs and donors contributed to the weakening of indigenous capacity, as the state was sidelined by decisions taken by donors and acted upon by NGOs. The subcontracting role also undermined NGO independence, as the competition for resources forced them to follow donor priorities. The state did not

collapse, however, tenaciously maintaining its basic functions (including public services) in accessible areas. Its recovery after the worst was over was built on this resilience.

The failure of the peace process in Angola inspired the creation in Mozambique of a huge peacekeeping operation, which insensitively pursued the short-term objectives of the Peace Agreement. The aid provided to sustain the peace process appears to have exceeded or misread existing needs. Peace and willingness to recover normal life were the main thrust for displaced civilians, who spontaneously returned home. The misunderstanding by outsiders of the events taking place at grassroots level was patent in the design and implementation of a grossly inefficient process. With peace consolidating and the orderly transition to a multiparty democracy, relief activities were scaled down, and donor resources shifted to developmental activities and to other countries. Despite the decline of total aid registered since 1992, Mozambique is still held in special regard by donors, as confirmed by the generous response to the emergency caused by the floods of 2000.

The health sector in Angola

In Angola, the health sector has declined over recent decades, and has not adapted effectively to the turbulent context. Under-resourcing, low capacity, political and military instability and the turnover of top-level managers jeopardized the implementation of PHC-inspired policies formulated by the government. The inadequate network, mainly composed of oversized, high-tech hospitals concentrated in urban areas, the departure of most Portuguese skilled cadres and destruction in rural areas all compounded the problem, resulting in low service coverages and gross inequalities. Without the challenge of sustaining an expansive health network, the MoH acceded to pressures to invest in hospital-oriented care. The detailed plans developed over the years (in increasing detachment from field realities) were often overruled by political decisions and usually not supported by financial commitments. Continuity with the colonial past was patent in ambitious projects, which diverted resources from essential concerns such as expanding coverages, reducing inequalities and improving quality of care.

Whereas domestic financing shrank during the 1980s, due to rampant inflation, the aid provided by allied countries, mainly in the form of specialist assistance, was inadequate to fill the widening gap. The workforce expanded through the proliferation of low-level training in all provinces. Sweden, the European Union (EU), Italy and UNICEF were the main donors to the sector in the late 1980s, concentrating their efforts mainly in Luanda.

The performance of the pharmaceutical subsector has been marked by the lack of a pharmaceutical policy, poor coordination within the MoH, fragmented and inefficient procurement practices, ambitious and unsuccessful attempts to foster domestic production, and widespread pilferage, which have resulted in severe drug shortages.

Services fragmented along vertical lines under the pressure of external assistance, which partially filled the domestic funding gap. Urban and hospital care continued to absorb a large share of internal resources. During the peace window of 1991–92, the external presence increased dramatically. Proposals aimed at preparing the ground for postwar reconstruction were not incorporated into MoH policies, and were forgotten in the post-election crisis. The 1992–94 war inflicted heavy damage to the remaining, mainly urban, network and appears to have broken the MoH surviving managerial capacity.

During the ensuing “no-war-no-peace” period, capital shortage and the climate of distrust in the outcome of the peace process discouraged rehabilitation work. Only activities supported

by limited external resources were implemented. The central MoH, affected by serious dysfunctions, abdicated its policy-formulation role and progressively weakened its links with peripheral authorities. The World Bank, the EU and DFID tried unsuccessfully to fill the policy vacuum. By incorporating new trainees not needed by a sector whose output was stagnating, the workforce expanded dangerously, concentrating in urban areas.

During 1994–98 some progress was registered at the grassroots level, as donor agencies and NGOs supported rehabilitation and training. Service coverage expanded modestly and slowly. The collaboration between the two rival sides, brokered by UCAH, included the extension of MoH technical guidelines to UNITA health services and the reintegration of UNITA health personnel into the NHS. Unfortunately, the progress registered at ground level was inconsequential to the eventual failure of the peace process.

The lasting predicament of Angola, coupled with the chronic disruption of its health services, has had a profound impact on the health status of the population. Epidemics are raging; high rates of severe malnutrition are common and mortality rates exceed emergency thresholds. The Angolan health sector has gone through uninterrupted decline, as the structural flaws, which affected the system since independence, never tackled directly, have grown to reach dramatic proportions. Over the last few years the MoH has engaged in more proactive policy-making, producing documents which recognize the structural problems affecting the sector: chronic internal under-funding, low absorption capacity, huge inefficiencies, a bloated workforce and substantial inequalities in the allocation of resources. To solve these problems would require huge investment and painful measures, sustained over a long period and backed by uncompromising political support. The formulation of realistic policies is the precondition for sector recovery and for attracting external support to back key initiatives, such as strengthening management and financial systems, restructuring the workforce and investing at PHC-level.

The health sector in Mozambique

At independence, the new government made health care a cornerstone of its political agenda, nationalized all existing health assets within a unified health system, and launched an ambitious sector programme, whose dominant approach was PHC. The workforce expanded, through the creation of new PHC-oriented categories and accelerated training activities. An innovative drug policy was introduced, a mass immunization campaign was successfully launched, and the coverage of integrated basic services increased substantially. Successes notwithstanding, the ambitious plans conceived by the MoH exceeded implementing capacity and available resources, making the NHS unsustainable. The capital shortage undermined the efforts to rationalize the inherited network, which remained distorted and ill-supported by referral and support systems. The under-resourced training network produced mainly graduates of low professional level, who delivered low-quality care. Management capacity remained inadequate.

War exacerbated the prevailing problems and brought additional ones. Given the sector's political visibility, RENAMO targeted the health system in rural areas, wiping out past gains and exaggerating the prewar urban bias. Health workers were murdered and kidnapped. Supply lines became unreliable and the already weak referral and supervision systems broke down. The health network shrank to a cluster of facilities, located in secure areas and overstaffed. By the mid-1980s, as allocations to the social sectors progressively declined due to the deepening economic crisis and the war effort, the NHS had become totally dependent on external aid.

During the last years of war, dominated by emergency-oriented activities, the sector was flooded by external resources, which stimulated inefficient approaches to service delivery. To speed up operations funding criteria were relaxed. Monitoring and evaluation were neglected, as the existing limited management capacity was overwhelmed by a myriad of projects. Investments benefited safe areas, making imbalances worse. External initiatives consistently bypassed the MoH, which was nevertheless expected to supply staff and shoulder the recurrent costs of unplanned facilities. NGOs launched independent and self-contained projects, venturing into new fields, such as rehabilitation, where they often lacked adequate expertise. NGO distribution was uneven, driven as it was by operational convenience or political expedience, inducing inequities still visible today.

Comment [Comment1]: EP: Land of Opportunities..January 29, 1998

In 1989, the MoH launched an ambitious exercise to prepare plans for reconstruction. Most of the involved cadres were well acquainted with the sector context, and aware of the system's weaknesses; however, none of them had been confronted by the enormous challenges of a reconstruction process. The information system was strengthened, and a limited but solid information base was assembled, permitting sensible decision-making. Frameworks for postwar reconstruction, completed before the peace agreement, stressed equity and affordability, thus attracting considerable donor support. The planning exercise kept central officials concentrated during a period of military stalemate, contributing to a relatively high morale within the MoH and avoiding the loss of key cadres.

Outside the inner circle of decision-makers, the stated objective of re-establishing the prewar situation prevailed, disregarding changes that had occurred and thereby perpetuating old biases in service provision. The war, perceived as the central constraint to service delivery, screened structural weaknesses, including urban and hospital biases, inadequate management capacity, poor training and support systems, over-ambitious goals and precarious financing. The NHS, perceived as fundamentally healthy, was expected to recover spontaneously with the advent of peace.

The misplaced nature of these expectations became clear in 1993, as operations slowed down and service output contracted. Running health services after the peace agreement was far more difficult than had been anticipated. Health workers were reluctant to move out of the main towns. Rebuilding in devastated rural areas was slow and expensive, and the huge costs of the transitional period offset the peace dividends. In the frantic climate of the transitional period, the pressing demands of reconstruction sidelined planning activities. Thus, the plans finalized by 1992 were successfully implemented, whereas areas lacking a clear MoH policy were left open to many inconclusive donor-led proposals. The massive resource reallocation, induced by the implementation of the MoH plans, benefited neglected regions, propelling since 1994 a sustained expansion of service outputs.

During those years, service provision in RENAMO-controlled areas was high on the agenda of many donor agencies. Despite mutual distrust and occasional incidents, both parties allowed NGOs to revive services in these areas: the political significance of the indirect collaboration between hostile sides was remarkable. Often, health services were the first signs of the coming normalization of civil life. A comprehensive programme to retrain RENAMO health workers and to reintegrate them within the NHS was implemented, defusing a source of tension and showing the MoH's willingness to proceed on the reconciliation path. RENAMO came to accept health workers from the government side to staff health facilities

in their own areas. The whole process powerfully contributed to the progressive reintegration of rebel areas into a common administration.

Efforts to improve donor coordination, started in 1990–92, were quite successful at the central level, mainly due to energetic action of the lead agency (Swiss Development Cooperation). New instruments aimed at rationalizing aid, such as sector budget support and pooling arrangements for technical assistance and drugs, were introduced. Information on resource allocation and service outputs was made available to agencies and NGOs, making possible a fruitful partnership with the MoH.

Due to its highly sensitive political dimension, the health component of the demobilization programme, managed by ONUMOZ with WHO support, was controversial. Security problems in some RENAMO assembly areas, divergences between NGOs and WHO, and the weak capacity of the contracting agency were the main complaints. The central role played by WHO (even with limited resources) was not sustained by the country office, nor by headquarters, which missed an opportunity to contribute to the reconstruction process.

After 1995, the fragmentation of external assistance decreased, as many relief-oriented agencies and NGOs scaled down and eventually closed their operations. Large investment programmes (still underway today) were launched to complete reconstruction. Meanwhile, the workforce has been restructured and redeployed along lines broadly following original plans.

Summing up, adaptive changes against a backdrop of continuity have been the prominent feature of the Mozambican health sector. Despite many detours, the health sector has proceeded towards agreed goals, guided by relevant, flexible and realistic policies. The NHS has survived economic crisis, war and natural disasters and recovered after war, expanding the delivery of health services to cover underprivileged areas, and securing sustained donor support through turbulent times. However, as the reconstruction momentum fades away, this outstanding adaptive capacity cannot be taken for granted. Policies are becoming blurred; worrisome signs of contented passivity accumulate, inducing concern about the future development of the National Health Service.

A framework: health-related dimensions of peace processes

Historical In Mozambique, the window of peace enjoyed soon after independence allowed the MoH to introduce its PHC-oriented policies, which gathered broad international support. In Angola, immediately engulfed in war at independence, PHC policies were considered and endorsed, but not resolutely implemented. The war conveniently justified this limited commitment, providing space to urban elites concerned with tertiary care, and denying managers the opportunity to learn hands-on. Not tempered by field experience, policies remained vague.

Political In Mozambique, the perception of health as a political statement, ingrained in the early socialist approach, made health services a target, to be destroyed by RENAMO, a military organization bent on destabilizing the state, which neglected service delivery in its mainly depopulated areas. In Angola, the government has shown a decreasing interest in social sectors, abandoning them to NGOs in rural areas and in secondary cities. UNITA, with an embryo political programme, and large populations under its control, has reportedly provided rudimentary services in the areas under its control.

Economic Mozambique, poor in natural resources, had to struggle to survive and has been more dependent on aid and on regional relationships for its service economy. Thus, by providing incentives to both sides for reaching a peace deal, donor leverage has strongly influenced the peace process. Angola, confident of its natural wealth, has been less active in mobilizing external resources. External partners, sceptical about MoH policies, commitment and implementing capacity, have remained unforthcoming in their support of the health sector.

War economy In Mozambique, RENAMO's predatory strategy proved self-defeating: the drought of the early 1990s accelerated the exhaustion of its resource base. In Angola, the war economy has taken "commercial" patterns, with the emergence of a merchant class exploiting resource-rich enclaves, in alliance with the elites of both parties and external powerful players. This brand of war economy coexists with the more traditional predatory variety.

Military In Mozambique, the cross-front health activities of NGOs contributed to decreasing tensions and to dismantling military control of people movements. Further, investing in health since independence stimulated the emergence of a peace-oriented influential elite. This high profile for the health sector has reassured donors about the government's aims and capacity, and attracted substantial resources. In Angola, cross-front health activities have been less prominent, because of controls on the circulation of outsiders and heavy mine density. The Angolan army has absorbed a large number of cadres, depleting other sectors of talented young people.

Ethnic Whereas the roots of the Mozambican civil war have to be sought in apartheid aggression, in FRELIMO's economic failures and in its authoritarian instincts, RENAMO's rise introduced a strong ethnic connotation to the political debate. Despite resentment against the dominance of Southern cadres within the health sector, health care provision was not seriously affected by ethnic concerns. Reconstruction has been biased towards less privileged regions by donors and government, hence tackling existing imbalances in service provision. In Angola, the ethnic divide is reinforced by the disproportionate share of resources allocated to Luanda, which has contributed to fuel ethnic grievances. However, beyond allocative distortions, there is no report of deliberate bias in health care delivery based on ethnic consideration.

Symbolic In Mozambique, the delivery of health services in areas previously inaccessible was seen by destitute villagers as a sign of normalization of life. Everybody, political affiliation notwithstanding, sought renewed health services. In Angola, the absence of substantial sector investment in war-battered areas confirmed the lack of confidence in the peace process. Services always took second place to military concerns.

Psychological Even at the peak of the national crisis, Mozambicans perceived their tragedy as a one-off event. This may explain the MoH commitment to develop elaborate reconstruction plans, which proved valuable in controlling the chaos of the transitional period. In Angola, as the endless war context postpones and sidelines discussions about the future health sector, reconstruction could start without any endorsed strategy, with ominous consequences.

Magical Reportedly, magic and supernatural powers have played a more important role in Mozambique than in Angola. Various instances of spirit mediums exerting influence over the

war course have been documented in the former country, while in the latter similar occurrences have not been reported. The disruption of traditional life brought about by the massive urbanisation of Angolans could be part of the explanation.

Reconciliation In Mozambique, several developments showed commitment to the peace process: the reintegration of RENAMO health workers into the NHS, the government's acceptance of relief activities in RENAMO areas and the joint planning of the health component of demobilisation. The peace process was marked by traditional rituals, aimed at marking a departure from the painful past, which were immensely influential in setting the population on a peace-building path. In Angola, mistrust, reinforced by entrenched ethnic rivalries, prevailed over reconciliation attempts. Abstention from equivalent ritual reconciliation practices suggests a widespread disbelief in the peace process. Joint initiatives and success stories at local level to promote reconciliation had little impact at national level.

Sociocultural Mozambique is culturally and geographically open to, and dependent on, the outside world. Mozambicans, used to dealing with external influences, interacted actively with foreigners involved in the peace process. The Angolans, more diffident (with good reasons, given the heavy enmeshing of foreign powers in their conflict), have kept outsiders at arm's length.

Standing and role of health authorities In Mozambique, continuity with a progressive past, consistency of policies and technical capacity gave credibility to the MoH, which won allies among donors and NGOs. Although fragmented, the health sector maintained a sense of direction during the transitional years. In Angola, vague policies not consistently implemented and difficult dialogue with partners have undermined the MoH standing. Without MoH leadership, coordination efforts have never materialised into concrete joint action.

PHC policies and service outputs The MoH in Mozambique invested heavily in the training of PHC-oriented cadres, while in Angola, the prevailing hospital model has sidelined the training of appropriate health workers, such as midwives. It seems plausible to conjecture a relationship between the much higher service uptake in Mozambique (in urban settings, where comparisons are possible) and the sustained enforcement of PHC policies.

Drug policies The radical drug policy adopted in Mozambique has met with tremendous success, visible to date, providing huge returns in terms of drug availability and attracting unqualified donor support. In Angola, the pharmaceutical area, only partially reformed after independence, has grown progressively more fragmented and deregulated. Inefficiencies and wastage, exacerbated by internal under-funding and hesitant donor contributions, have resulted in chronic drug shortage.

Opportunities offered by a transitional environment The two health sectors reacted differently to the similar challenges they faced. Whereas initiative, risk-taking, investment in information and forward planning prevailed in Mozambique, passivity, neglect of information and vertical approaches undermined the capacity of the Angolan sector to adapt to the changing context. In Mozambique, the opportunity offered by reconstruction of building a better health sector was successfully seized, bringing improvements in terms of accessibility, equity, appropriateness and long-term sustainability. In Angola, scepticism about the end of the war has undermined the debate about reconstruction. The recent promising attempts in this direction need further development and full political backing to be borne to fruition.

Institutional settings of the humanitarian coordination body In Mozambique, UNOHAC, the UN humanitarian arm integrated in the peacekeeping operation, put the humanitarian dimension firmly on the agenda. This potentially contentious institutional setting proved to be effective within a successful peacekeeping framework. Conversely, in Angola, UCAH was kept separate from the other components of the UN peacekeeping operation, in this way giving the humanitarian body space for manoeuvring and making it “neutral” in the sensitive Angolan environment. Agencies and NGOs could rely on the direct transfer of expertise, as many professionals who had previously worked in Mozambique, and gained precious experience, moved thereafter to Angola.

Scope of the peace process In Mozambique the peace process encompassed most dimensions, hence the relatively high profile enjoyed by health. Health authorities were able to associate themselves with the NGO-led forward thrust, presenting to rural populations the state as service provider. The scope was narrower in Angola, as it focused on military and political control, little attention being paid by the government to social services in rural areas. Strained relationships with NGOs precluded health authorities from taking full advantage of the process. People were confronted first with the state as controller.

Documentation, memory and knowledge These aspects are quite well developed in Mozambique, in terms of both written materials and expertise. Memory is particularly weak in Angola, as most actors have left the stage and little is written down. Available analyses are weakened by a deficient information base, where gaps and inconsistencies undermine every dataset; long-term trends are hard to discern and successful initiatives are forgotten. This gap is caused by several factors, including the intensity and duration of the war, the disruptions suffered by the health system, the general lack of confidence in a favourable outcome of the conflict, the control exerted by the security apparatus, and the limited scale of aid-associated research.

Discussion

Several lessons can be drawn, mainly from the Mozambican experience, which apply quite comfortably to Angola and possibly to other troubled countries emerging from conflict.

- The approach of “return to the prewar situation” has been shown to be flawed. In Mozambique, the past success, despite its patent drawbacks and linkage to an extraordinary historical context, was idealized, ignoring the changes that had affected the country. In Angola, once reconstruction eventually starts, the temptation to indulge in the same back-to-past fallacy, fuelled by over-optimistic estimates of the internal financing capacity, might be strong.
- Reconstruction represents a unique chance to build a balanced and equitable NHS, as it offers the opportunity to reconsider the whole system and plan it on a comprehensive, rational basis. Large resources may become available for investments addressing major allocative distortions.
- To reduce the unavoidable chaos of transitional situations, comprehensive planning *before* peace is critical. Entering into a transitional phase without a well-conceived strategy is much worse than wasting energies in elaborating plans made obsolete by the recrudescence of military activities (as in Angola). Situation analysis and documentation are, therefore, priority activities. As information in unstable situations becomes rapidly outdated, the data collection and analysis required in these contexts are necessarily “quick and dirty”.

- Charged with sensitivities and providing enticements to all players to push ahead with civil works, reconstruction is more difficult than expected during a war period. In Mozambique, no detailed plans consistent with the national strategy were developed at provincial level, leaving room for improvisation. Rehabilitation standards were often poor, and funds to cover start-up costs of newly constructed facilities were seldom allocated by donors. Those areas with relatively better security or easier access were over-resourced, introducing unsustainable patterns of service delivery still patent today.
- Rehabilitation and reconciliation go together, but confront governments and aid agencies with difficult choices. In the aftermath of a peace agreement many crucial aspects are unpredictable (e.g. the political outcome and return and resettlement patterns), while expectations are high. Waiting for the consolidation of the peace process to invest in politically risky initiatives can undermine reconciliation efforts. In Mozambique, the haste of aid agencies to implement short-term, visible projects often resulted in the wastage of resources or in the addressing of low priorities.
- The coordination of external support is essential. When the reconstruction process is highly dependent on donor-fragmented resources, as in Mozambique, aid management is crucial. Given the government weakness and the limited capacity of any single player to enforce policies, the chosen plans, explicit in their rationale and specific about ultimate goals, should aim to inspire reconstruction, rather than to control it. Strong, consistent leadership by the MoH may be the essential factor to solidify donor support around shared goals. Without it, fragmentation and inefficiency become inescapable patterns.
- Political rationale often ignores technical advice, as has frequently been the case in Angola. In Mozambique, the tension between the realistic, technocratic approach, which acknowledged the resource shortage and weak capacity, stressed sustainability, efficiency, and modest targets and the confident, political, need-driven approach, which pushed for ambitious objectives, permeated the policy discussion at every level. In transitional situations, the latter approach may pay off in the short term, at the price of postponing difficult decisions and creating future problems. This danger can be contained by solid technical analysis, which highlights present and future costs of available alternatives. The fertile interaction between technical and political actors has been one of the factors behind the Mozambican success story.
- To anticipate events and constraints is crucial. In Mozambique the reluctance to introduce cost-recovery led to a widespread system of informal charges. Imposing a cost-sharing system after years of *laissez faire* brings additional challenges and greater resistance. In Angola, deregulation and privatisation (formal and informal) of health care have proceeded even further.
- Costing projections, elaborated during the war, tend to underestimate actual needs. As the network expands to cover remote areas, reconstruction is more expensive than anticipated, and recurrent costs tend to be underestimated in decision making and planning. The instability of transitional situations makes estimates quickly outdated.
- There is no rapid solution to the massive disruption induced by a protracted civil war and economic crisis. The merit of appealing solutions during wartime, for example vertical programmes and separated supply systems, should be weighted against their long-term effects. Potentially disruptive schemes should be introduced only as extraordinary measures for short periods, and withdrawn as soon as normal operations can be resumed. The standards common in emergency operations are not transferable to post-crisis health services, in which resources, skills and motivation are disproportionately scarcer. To avoid the frequent collapses experienced when projects withdraw, more modest interventions are required from the beginning.

- Increased knowledge among donors and implementing partners about the host country is crucial for developing relevant and effective strategies, in both relief and rehabilitation phases. Humanitarian organizations tend to rely on standard procedures insensitive to local patterns. In Mozambique, the presence of professionals knowledgeable about the country, and the existence of a comparatively rich information base, represented for incoming agencies an advantage relative to Angola.
- In a disrupted and dependent country, donor judgement about the worth of the state as a partner may have decisive consequences. As the choice of working outside the public sector weakens an already weak administration, serious efforts to work with local authorities should be made. In Mozambique, after some reluctance during the transition period, donors have become progressively more willing to engage with the government. In Angola, diffidence has prevailed and sincere attempts at developing fair partnerships have been rare and short-lived.
- Conflict provides a unique opportunity to strengthen a health sector's human resource capital. As most health workers are concentrated in overstuffed facilities, a retraining programme, aimed at preparing them for the duties they will face once peace is secured, can be launched with almost no disruption to service provision. Distortions in the workforce structure can be corrected, skills can be upgraded or new approaches can be taught. Additionally, a retraining programme may keep stressed health workers concentrated on core professional content, and bound to the health system, thereby preventing attrition. The seizing of this opportunity has been one of the distinctive components of the Mozambican process. A serious problem arises when the sector's workforce has grown out of control (as in Angola) and a painful restructuring, requiring firm political backing is in order.
- Learning from previous conflicts and reconstructions has not influenced local decision-makers in the two countries. Serious and protracted crises look unique to local actors, who, absorbed by their situation, neglect experience from abroad. Without learning, and dissemination of what has been learned, no effective response to crises can be expected. However, learning in a disrupted environment is arduous, as documentation is lost and key actors move to other duties or countries. A prospective approach, in which analysis and documentation start with other activities and continue in a sustained way, is needed for the crises to come.

Conclusions

The picture emerging from the analysis of the health sectors in Angola and Mozambique is one of remarkable differences at all levels. Five broad lessons may be drawn from this analysis.

- 1 When there is a genuine thrust towards peace and reconciliation, health development can play a catalytic role. In Mozambique, the sector recovery was a visible success, spearheading and giving credibility to the whole peace process. However, a positive role for health is possible only if a previous sustained investment in the sector has made it politically significant to contenders. Further, where there is no willingness to pursue peace, peace-oriented efforts in the health sector become immaterial, and health care provision is reduced to damage control. In Angola, the fate of health services can be seen as a low-profile failure, within the global collapse of the peace process. The approach to health development depends, therefore on the informed reading of each political situation, rather than on principled strategies or guidelines elaborated far away. When the conflict has degenerated into predatory warfare deprived of political goals, health is inevitably sidelined. Where violence against the civilian population is an important component of

the military strategy, health services represent an obstacle or a target and cannot contribute to reconciliation. This explains why the interactions between health and peace have been documented in several reconstruction contexts, whereas much lesser evidence is available on the positive role of the health sector in conflict prevention and mitigation.

- 2 In the long term, passivity on the government side rarely pays off. In fast-evolving transitional situations, to wait for more propitious environments may result in missing unique opportunities. Forward-looking and risk-taking are mandatory, but likely to succeed only when informed by robust analysis.
- 3 Given the overcrowding of conflict and post-conflict situations with multiple autonomous players pursuing their own agendas in isolation, investment in information, aimed at composing a reliable picture of the whole health sector, is paramount to redirect actors, to reduce fragmentation and to promote consistency of initiatives.
- 4 Knowledge of and sensitivity to local contexts, in order to build on local strengths, are preconditions of successful interventions. The complexity of the prevailing emergencies calls for new fields of expertise. Technical competence and field experience alone do not equip health professionals with the ability to understand the context in which they are operating. Beyond economic, social and cultural analysis, elements of political, military and strategic understanding are required.
- 5 Several policy lessons derived from the Mozambican case could be adapted and usefully applied to Angola and other war-affected countries, if and when they reach a peace settlement. In Mozambique, awareness by the Ministry of Health and aid agencies of the lessons learned in other post-conflict sector recoveries would have controlled ill-conceived and inefficient interventions.

1 Introduction

This study was commissioned by the World Health Organization, Department of Emergency and Humanitarian Action, under the Health as a Bridge for Peace programme, co-funded by Italy and DFID/UK. Its main aim is to analyse the health sector in Mozambique and Angola since the late 1970s, in order to draw and document lessons on the possible influence of sector investment in mitigating conflict, fostering reconciliation and clearing the path for recovery, which may be useful in similar complex emergencies. Mozambique and Angola provide a good example of two countries that, having many common features at independence, then evolved along strikingly divergent paths. Thus, the conflicts that have for so many years marked their politics, economies and societies have culminated in opposite outcomes.

More specifically, the objectives of the study are to:

- a) explore the contribution of the health sector in creating or promoting opportunities for peace;
- b) compare the two countries with respect to the role of the different players, factors and context, internal and external, in shaping events in the health sector;
- c) analyse the capacity of the health sectors in the two countries to respond to the health needs of the population, in a context of economic crisis, war and disruption; and
- d) discuss the post-conflict challenges and opportunities of the sector rehabilitation in Mozambique, which are likely to present themselves also in Angola and in other countries affected by conflict, once a peace settlement is reached.

It has been documented in several countries (Zwi et al., 1999; Ugalde et al., 1999) that the development of health services can play a positive role in mitigating political tensions immediately after a period of conflict, as has occurred in Mozambique. There is less evidence for the health sector's sustained contribution to reconciliation during a period of crisis, however, as experience in Angola, and, to a lesser extent, in Mozambique shows. This study attempts to analyse the conditions and circumstances under which the health sector can contribute to the peace process.

Contextual, external factors exert a strong influence on health sectors, in terms of policy formulation, implementing capacity and external support. A comparative analysis of the health sectors of Mozambique and Angola in different phases of conflict and post-conflict, therefore, calls for an understanding of the histories and different political, economic and military contexts of the two countries. On the other hand, the analysis of humanitarian crises and their impact on health and on health sectors reveals a number of common features, regardless of the specific context of the country or the root causes of the emergency: "population displacement, food scarcity, malnutrition, high morbidity and mortality, including violence intentionally directed at civilians, and severe mental stress" (WHO, 1999).

The severity of the impact of conflicts on health has been found to vary according to the scale and duration of violence, the possibility of fleeing to safe havens, and the degree and effectiveness of assistance provided (Zwi et al., 1999; Ugalde et al., 1999). Attacks on health systems have become common components of military strategy in civil wars, and the consequences for sector policies, financing and staffing have been analysed in countries as diverse as Uganda and Cambodia (Macrae et al., 1993; Lanjouw et al., 1999).

In different contexts, health sectors faces common challenges:

- meeting increasing health needs with reduced resources during the conflict;
- defining a recovery strategy once the emergency is over;
- publicly run health services, by belonging to states whose legitimacy is being challenged, face additional difficulties;
- the same dilemmas of neutrality, legitimacy and sustainability of emergency relief confront aid agencies in most conflict situations (Macrae, 1997).

These factors account, at least partially, for the remarkable similarities found in the policy and practice of international aid (Bradbury, 1998). However, as most current conflicts are characterized by complex political and economic dynamics, and originate from tangled historical and structural antecedents, an informed understanding of the context is crucial if neutrality and impartiality are to be preserved, and if adequate assistance is to be provided. Duffield, in a study on Angola and Bosnia, has argued that similar humanitarian interventions have been carried out in dissimilar social and economic systems, concluding that “relief operations are functionally blind to the specific conditions that confront them” (Duffield, 1994a). The implications of this peculiar insensitivity of the aid industry to context will be discussed below in relation to Mozambique and Angola.

2 Methodology and scope

This study uses a comparative approach to identify common factors and particularities that have contributed to shaping the present political and economic contexts of the two countries, and, within those contexts, to analyse the strategies adopted by the health sectors and to assess their capacity to respond to the health needs of the populations. This approach is intended to enable understanding of features of each country and sector which might have been missed or misjudged if studied in isolation.

Extensive searches and successive review of the published and “grey” literature on the two countries were carried out (see References). During this phase, the important information gap, which exists between the two countries, emerged indisputably. While the literature, both general and sector-related, on Mozambique is extensive, much less has been written on Angola (Minter, 1994; Cahen, 1997; Green, 1999), particularly on health. “A basic fact about Angola, then, is that it is barren of facts” (Sogge, 1992). This imbalance was exacerbated by the much greater familiarity with Mozambique of the authors of this study. Written sources on Angola were therefore supplemented by a questionnaire, which was submitted by electronic mail to 27 informed persons, of whom 19 replied (see Acknowledgements). Direct interviews were carried out in Maputo, London, Washington DC and Luanda.

The preliminary findings were discussed at a debriefing at WHO in Geneva in June 2000 and presented in a seminar, eliciting useful comments. The draft report was widely circulated for feedback and presented at the Conference of Social Science and Medicine (Eindhoven, October 2000) and at the Conference of the Canadian Public Health Association (Hull, November 2000). The received comments, when considered relevant by the authors, have been incorporated in this final version of the report.

Structure of the report

Chapter 3 provides the background to the study, focusing on the changes that have affected the international humanitarian system since the end of the Cold War. It reviews the militarization of the relief system, the increased burden placed on the UN system for humanitarian intervention, the subsequent expanded task-sharing of military operations (through the use of regional organizations and the sub-contracting of NGOs) and the organizational changes occurring within the humanitarian system. The paradigm of the “relief to development continuum” is briefly discussed in relation to the new perspectives and theories concerning the cause and nature of complex emergencies. Finally, the main theme of the study is anticipated: the progressive divergence of the two countries since independence, with regard to the outcome of war and economic prospects.

Chapters 4 and 5 analyse retrospectively the two countries in relation to the internal and external contexts of the emergency and the main actors involved in humanitarian assistance in general (i.e. without specific references to the health sector). The chapters aim to highlight the main differences between the experiences of the two countries in terms of donor response, the role of governments and insurgent parties, and in the institutional arrangements put in place for emergency coordination and peacekeeping operations.

Chapters 6 and 7 review the health sectors in the two countries, in terms of policies, internal and external players, and responses to war challenges. Chapter 6 on Angola tracks the downward evolution of the sector over the years, induced on the one hand by the forbidding

environment, which prevailed in the country, on the other by the inability of the sector to adapt effectively to the situation. Under-resourcing has been compounded by unrealistic plans, vague policies, lack of leadership and fragmentation. At the beginning of the new millennium, the Angolan health sector needs to reinvent itself from scratch. It will be a difficult, painful and slow process. Chapter 7 on Mozambique focuses on key issues in the transition period: the “return to the past” fallacy, the chance of rebuilding a better health system offered by the peace environment, the challenges confronting health planners and external agencies in the reconstruction of the sector, the requirements for coordination and leadership and the risk of wasting scarce resources through inefficient approaches. The innovative approaches, which have enabled the health sector to take advantage of the situation and to emerge strengthened from crisis, are discussed.

Chapter 8 lays out a framework for comparing various dimensions of the peace process in relation to health in the two countries. Its main aim is to help understand why health has played such a different role in the two countries, on the basis of the analysis of the influences that have affected the sector and of those that the sector itself has exerted on other domains. The framework uses a comparative approach to shed light on a wide range of areas in which differences, more than similarities, can be identified.

Chapter 9, Discussion, and Chapter 10, Conclusion, bring together the key issues from the preceding chapters and draw out lessons that may be relevant to other contexts of health emergency.

To help the reader to follow events, a detailed chronology of general and health-related events in Angola and in Mozambique from 1975 to 2000 is presented at the end of the report.

3 Background

Changes in humanitarian intervention

Dramatic political changes at international and regional level have had a profound impact on the two countries in the period covered by the study. The end of the Cold War resulted in a different configuration of political interests and balance of the forces behind the conflicts. The demise of the apartheid state and the transition of South Africa to a multiparty democracy have exerted obvious détente effects, and have greatly contributed to Mozambique's peace and stabilization in the critical postwar period. The independence of Namibia and more recently the fall of the Mobutu regime in Zaire have been influential events in the Angolan war, the former reducing direct military support from South Africa to the National Union for the Total Independence of Angola (UNITA), the latter blocking its favourite supply route. However, economic and power interests have proved stronger than the withdrawal of external support in fuelling the Angolan war, now in its fourth bout of recrudescence.

Profound changes have also occurred in the humanitarian system. The early 1990s witnessed a more aggressive and interventionist role of Member States of the UN (Borton, 1998). UN peace-building operations with a strong military component were deployed in civil wars, with declared humanitarian objectives. Examples are the intervention in northern Iraq in 1991 to create safe havens for Kurds, the creation of UNPROFOR in the former Yugoslavia in 1992, and the deployment in the same year of US troops alongside the UN peacekeeping operation in Somalia. Between 1988 and 1994, 21 UN peacekeeping operations were launched, as compared to only 13 between 1948 and the end of the Cold War, in what has been called "the militarization of the international relief system" (Slim, 1995).

After the debacle in Somalia, the US and some other Western countries radically changed their attitude, choosing not to intervene in civil wars in non-strategic countries (i.e. those peripheral to their political and economic interests). Arguably, as a result of this shift, and despite mounting awareness of the impending disaster, no timely UN military intervention took place to avert or at least to stem the Rwanda genocide. To counterbalance the progressive disengagement of Western powers and the UN lack of political and military clout, the participation of regional forces, such as the ECOMOG in Liberia and Sierra Leone and the CIS peacekeeping force in Georgia, was promoted.

Recent events in Kosovo, East Timor and Sierra Leone suggest that the international community is far from taking a consistent approach to the mounting wave of political and humanitarian crises which affect the "new international (dis)order". As a matter of fact, not every crisis is perceived as equal by Western countries. In fact, they have regarded Kosovo as a situation deserving aggressive military action and a massive relief/rehabilitation effort, while Iraq was target of military but not of proportional humanitarian intervention (also because of sanctions). Finally, Afghanistan, Sierra Leone and Angola have attracted little attention and support, conceded half-heartedly mainly at the peak of their crises. The inconsistency (or better political selectivity) in donor attitude towards humanitarian crises is well illustrated by the fact that in 1999, in response to the UN appeals, the international community gave US\$207 a head for Kosovo and the rest of former Yugoslavia, US\$60 for Sierra Leone and only US\$8 for the Democratic Republic of Congo (Oxfam, 2000).

In an increasingly globalized world, where capital flows do not recognize borders, international relations are changing. The principle of “the right and duty to interfere”, invoked long time ago by Médecins sans Frontières (MSF) as a moral principle to guide humanitarian interventions (Fox, 1995), has gone a long way, embraced as it is today by UN Member States to overrule the once sacred principle of sovereignty. In Kosovo, with the military intervention of a regional organization, NATO, violating the sovereignty of a state and acting independently of the UN, an innovative approach has been introduced (Ramonet, 1999). The uncertainty about how to tackle the new class of crises is compounded by the growing cost of peacekeeping operations¹ and relief aid, which escalated in the late 1980s and in the first half of the 1990s, in a context of overall decreasing overseas development assistance (ODA). Thus, emergency relief, which accounted for 2 per cent of ODA in 1980, had increased by 1994² to 15 per cent³. The UN peacekeeping interventions in Mozambique and Angola were part of this policy shift in the early 1990s: they will be analysed in the following chapters, with special emphasis on their humanitarian component.

In the same period, organizational changes took place within the humanitarian system: the UN Department of Humanitarian Affairs (DHA), now the Office of the Coordinator for Humanitarian Assistance (OCHA), replaced the UN Disaster Relief Organization UNDRRO; UN Executive Committees were created at headquarters to improve inter-agency coordination; the number of Special Representatives of the Secretary-General (SRSGs) grew substantially and their role in unifying the UN agencies at country level was strengthened, and a European Community Humanitarian Office (ECHO) was established. These reforms reflected the need and at the same time the difficulty of defining an authoritative and effective institutional framework for the coordination of humanitarian response.

It has been argued that the humanitarian space remains overcrowded, with substantial overlaps between agencies, and fierce competition for resources that are increasingly inadequate to respond to mushrooming humanitarian crises (Munslow and Brown, 1997). Moreover, the boundaries between the role and structure of the coordination of humanitarian response and the political and military components of peacekeeping operations are often blurred. Furthermore, the field suffers from considerable conceptual problems, often masked by the uncritical espousing of ideals, such as reducing the role of the state, according to the dominant neo-liberal economic and political thinking (Duffield, 1998a).

These difficulties are exacerbated by the attacks that humanitarianism is suffering from different sources (such as the media, donor agencies, pressure groups and developmentalists) regarding: its capacity to reduce human suffering (Macrae, 1998b); its weak consistency with the foreign-policy goals of donor governments; and the risk of undermining local institutions, thus inducing dependency of beneficiaries on external assistance. Critical arguments, increasingly voiced by the media, are that humanitarian interventions can be easily manipulated by warring sides for military purposes, that relief seldom addresses the root causes of conflict, and that it can even contribute to its prolongation or exacerbation, giving legitimacy to one side or unwillingly becoming part of the local political economy of war (Keen and Wilson, 1994; Hendrickson, 1998).

¹ Their cost doubled from US\$2.4 billion in 1990 to US\$5.7 billion in 1994 (Macrae and Leader, 2000).

² The peak year, during the Rwanda crisis.

³ Data from the Development Assistance Committee, 1995, quoted in Macrae (1998a).

New types of conflict

The paradigm of the “relief to development continuum”, based on the natural-disaster model of crisis and enthusiastically adopted in the early 1990s by most academic institutions and operational agencies, has proved to be untenable in most complex emergencies. This model envisages a linear transition from war to cease-fire and peace, which is paralleled by an equally linear sequence from relief to rehabilitation and development. Accordingly, “technical” solutions, such as food aid or other supplies, can help to restore the pre-emergency situation, provided that a link between relief and development interventions is pursued.

The conventional view that conflict is an abrupt, but temporary crisis of society, “a temporary aberration in the development process” (White and Cliffe, 2000) is today contrasted by a more realistic conception of it. War is not seen as an external event, which hits the social system and has its basic roots in underdevelopment, but as the manifestation of innovative and brutal forms of political economy in poor countries, progressively marginalized by increasingly asymmetric economic and power relationships in a globalized world (Duffield, 1998a; Macrae, 1998). A new term, “ungovernable chaotic entities” (De Rivero, 1999), has been devised to define these non-state political arrangements⁴. Not only has the frequency of wars increased, but their characteristics also have changed. Most of them are protracted and self-sustaining, fought within national boundaries, with the creation of non-state, unruly predatory groups around illegal economies, alongside unclear ethnic, religious and political divides. They also have international dimensions, due to the substantial economic interests at stake, and the increasing fragmentation and deregulation that accompanies a reduced role of the state (Le Billon, 2000).

The Angolan case illustrates the transition to a new typology of war: the linkages between the belligerent parties and the outside world are no longer ideological or political, and the global trade of oil, diamonds and arms (and aid) fuel the war economy. The fact that war offers economic opportunities unthinkable in a peace environment explains why the continuation, rather than the resolution of the conflict is pursued by powerful groups (Hodges, 2000; Cilliers and Dietrich, 2000). It has been observed that, rather than the continuation of politics by other means in the old Clausewitzian sense, warfare is now better understood as continuation of economics by other means (Keen, 1998, quoted in Duffield, 1998b). Some of the implications of these conceptual and policy shifts and organizational reforms on humanitarian assistance at field level will be explored in the following chapters.

In contrast to Angola, Mozambique has broadly fitted the continuum paradigm. However, recent events in the rest of the world suggest that the linear political transition to peace, which took place in Mozambique, is the exception rather than the rule (Macrae, 1999), thus confirming the overall limitations of the paradigm as a guide for understanding humanitarian crises and formulating approaches to deal with them. In Angola for example, the uncritical application of the continuum has contributed, during short periods of fragile peace, to

⁴ From the historian’s long-term perspective, however, these “innovative” responses look distinctively old, well established in the European Middle Age as well as in China, or in the first centuries of colonial activity (Berdal and Keen, 1997; Newitt, 1999). Far from being a modern organization (if not in the weapons it used), RENAMO replicated the structure, warfare techniques, military success and way of life of the Achikunda armies of the nineteenth century in Central Mozambique (Capela, 1988; Derluguian, 1989).

providing a false picture of development opportunities, with the serious consequences that will be described below in Chapter 4.

Humanitarian aid as a surrogate for direct engagement?

With the end of the Cold War, internal conflicts in poor countries no longer represent proxy battlefields of opposing ideological powers. Western countries have become more concerned about issues related to regional security and stability, such as population growth and migration (and in particular the containment of refugee flows to the West), economic collapse, international criminal activities, and their repercussions on globally inter-linked markets (Duffield, 1998a). As a consequence of this decrease of strategic interest, a vacuum in international politics has emerged, which under the slogan “African solutions to African problems” uses humanitarian aid as political surrogate for the direct engagement in more expensive and politically risky peacekeeping operations. “Rarely have politicians come up with a phrase that better masks what amounts to serious neglect” (Jones, 1999).

Since the introduction of structural adjustment programmes, donors and international financial organizations have increasingly used aid conditionality for leverage towards recipient countries, which are requested to conform to accepted standards of political behaviour and economic policy. On the other hand, humanitarian assistance does not necessarily require a direct engagement with the recipient countries, as it can be delivered by the private and voluntary sectors. In the extreme, but ever more frequent, case of “warlordism”, where the political map is complicated by the presence of “irregular” factions (e.g. Somalia), and the traditional tools of diplomacy prove to be inadequate, relief has the additional advantage of allowing donor governments to maintain a political distance from the recipient country (Macrae and Leader, 2000). As a result of this politicisation of humanitarian assistance, aid agencies and field workers, usually ill-equipped to bear substantial political responsibility, are confronted by difficult choices.

These policy and organizational changes in the relief system have been determined by the expansion of humanitarian space, induced by the increased freedom of UN Member States to intervene politically and sometimes militarily, in order to ensure access to relief in complex emergencies, and by the substantial growth in the number of civil wars. Between 1978 and 1985 only 5 conflict-related emergencies were reported (quoted in Lindenberg, 1999); between 1985 and 1995 26 civil wars were recorded (ibid.), and between 1989 and 1998 there were more than 23 (De Rivero, 1999).

It has become evident that development and humanitarian aid alone are insufficient to defuse internal conflicts, or contain the spread of regional security risks, if they are not backed by the political will of warring parties, as well of external players, to settle. The dramatic increase of internally displaced persons (IDPs)⁵ in recent years, resulting from the enforcement of regional and international policies, such as the closure of borders and the use of containment, to prevent refugee influx and restrict the arrival of asylum seekers in Western countries (Borton, 1998), provides a worrisome lesson. Enjoying less protection and assistance than refugees, due to difficult access to them in conflict areas, to the sensitive issue of sovereignty, and to uncertain organizational responsibility within the humanitarian system, IDPs represent probably the most vulnerable group among forced migrants (WHO, 2000). Meanwhile, attention has been recently paid to the coping strategies of the victims of violent

⁵ Estimated in 1995 at 23 million worldwide, as compared to 14 million refugees (Borton, 1998).

conflicts, whose resilience blurs the classifications retained by international bureaucracies and calls for a better understanding of events on the ground, to inform strategies and operations of assistance (Keen and Wilson, 1994; Bakewell, 2000).

Since the late 1980s, Africa has become the largest recipient of food aid and humanitarian assistance (Duffield, 1994b). Aid has been increasingly channelled through NGOs, which have ended up complementing, and in the extreme cases replacing, the state in the provision of basic welfare services: the proportion of non-military aid channelled through government declined from 95 per cent in 1976 to only 6 per cent in 1990 (Borton, 1994). This change in the way aid is channelled is part of a more fundamental ideological and political shift towards neo-liberal paradigms, resulting in the progressive disengagement of donor countries from recipient state structures. Donors have increasingly seen and used NGOs as a “magic bullet that can be fired off in any direction and will still find its target, though often without leaving much evidence” (Vivian, quoted in Edwards and Hulme, 1996).

Through the creation of alternative management systems, the enhanced role of NGOs in emergency relief has resulted in a progressive erosion of sovereignty and institutional capacity for coordination and implementation of relief operations of recipient countries. A vicious circle has been established: weak states in crisis need support, but the aid they receive may end up contributing to deepening the crisis and further debilitating their capacity. Civil servants from countries where the state is both performing and well established, preach the trimming of weak states and bless the rise of a civil society⁶, which is usually nowhere in sight (Harvey, 1998; Chabal and Daloz, 1999). A curious approach indeed, keenly indulged by officials who have very little to lose if their assessment proves wrong.

Comparing Mozambique and Angola

The Angolan war, which began in the context of the Cold War and is sustained today by different, largely indigenous causes, is a case in point of chronic complex emergency. To understand why and how Mozambique has followed a different path and has reached political stability and sustained economic growth, to inquire whether the sustained political investment in the health sector was a relevant component therein, and to explore whether the constellation of factors behind its favourable outcome can be realized elsewhere, are the central and more challenging issues to be addressed by this study. References to the historical context are made whenever it is considered relevant to the understanding of the issues under discussion.

At independence in 1975, Angola and Mozambique shared many common features: the legacy of the least developed colonial power, which had resulted in weak states, underdeveloped infrastructure and inefficient bureaucracy; a culture of authoritarian paternalism (Cahen, 1997); a limited human resources base, aggravated by the flight of the vast majority of Portuguese settlers; the adoption of Marxist-Leninist one-party-state systems; a strategic position in Southern Africa; and a neighbour as powerful, aggressive and ruthless as apartheid South Africa. At the same time, the differences were marked. The vastly poorer Mozambique had strong economic links with southern Africa, dependent as it was on the revenues remitted by labourers in South Africa and on the use of its ports and railways by the latter and by other neighbouring countries, such as Zimbabwe, Malawi and Zambia. Angola had relationships with Central-African, French-speaking countries; its bonding with Portugal

⁶ “The most overused, undertheorized word in the modern aid lexicon” (Jones, 1999).

was much stronger than was the case with Mozambique. Angola's economic links with Western countries were built on the conspicuous wealth associated with coffee production until the 1960s, and subsequently by the booming exploitation of its oil and diamonds. These riches put Angola high in the Cold-War agenda, as eloquently demonstrated by the prompt South African invasion in the aftermath of independence.

A quarter of century later, the similarities have become diluted, and the differences have dramatically broadened. Angola, potentially one of the richest countries on the continent, is today in ruins, after thirty years of intermittent, often high-intensity, warfare which have devastated its economy and social fabric. Petrodollars and diamonds enable both the continuation of the war and the survival and prosperity of the two competing leaderships, at the cost of further degradation in the living conditions of the population (Global Witness, 1998 and 1999).

In Mozambique, the transition to peace from what was then perceived (before the events in Liberia, Rwanda and Sierra Leone) as one of the most vicious African wars has proceeded smoothly. Stability, good rains and generous donor support have fuelled economic growth, through the expansion of agricultural production, followed by the recovery of the service and

Table 1 Selected indicators, Mozambique and Angola, 1998

	Mozambique	Angola
Population (million)	17	12
Density (population per km ²)	22	10
GNP per capita (US\$)	210	380
GNP annual growth (per cent)	12	5
Present value of debt (US\$ billion)	2.9	11.5*
Total debt service (US\$ million)	105	1,353
Aid per capita (US\$)	61	28
Human Development Index**	169/174	160/174

* Considered greatly under-estimated by many sources.
Sources: World Bank; ** UNDP Development Report 1999.

manufacturing sectors and a massive inflow of foreign investment. Ten years ago, no one could have predicted that Mozambique would have enjoyed the world's fastest-growing economy, with an average 10 per cent annual increase in gross domestic product (GDP) for the past four years (*The Economist*, 2000a). It has been argued that this economic boom is fragile, built as it is on a narrow base, and reflecting a very low starting point. It represents, however, a

sizeable improvement over the past, as demonstrated by comparing the present meagre GDP of US\$210 per capita (Table 1) with the US\$132 estimated in 1970 (at 2000 current prices), towards the end of the colonial rule (Brück, 1997).

4 Emergency and humanitarian assistance in Angola

"The quickest way to end a war is to lose it."
George Orwell

Angola has been through forty years of war, only discontinued by periods of uneasy peace. Since the time when Angola ceased to be a Cold-War proxy battlefield, the intractability of its case has been based in the richness of its natural resources. Oil and diamond revenues are powerful incentives for competing parties to seek all-out victory to control them⁷. Economic interests, internal and external to the country, have replaced ideologies and opposing political blocks in fuelling the war. Moreover, in Angola the present ethnic divide among the opposing parties has deep historical roots, as the warring sides and their core leaderships descend from, and their support areas coincide with, definite pre-colonial states (Green, 1999; Cahen, 1997). Additionally, a larger-than-life protagonist, Jonas Savimbi, unwilling to abide to any conceivable rule, has made a negotiated settlement elusive (Prendergast, 1999).

All these factors combined explain why the linear process of transition of Mozambique, with peace bringing to the rulers the resumption of economic production and therefore some wealth, but not massive payoffs, is inapplicable to Angola (Green, 1999). War has become a constant feature of Angolan life, an all-encompassing screen behind which the results of poorly conceived and implemented policies are conveniently hidden, removed from scrutiny. In every field, be it macroeconomic management (Aguilar and Stenman, 1994; Aguilar, 1998) or the health services, crucial decisions are delayed again and again, making the underlying problems, perhaps as disruptive as war, increasingly refractory to solution.

Angola has been less active and less successful than Mozambique in mobilizing external aid, at least until the Lusaka Accord (Green, 1994), preferring to rely on commercial imports of food and other goods, considered politically more acceptable than requesting external assistance (Sogge, personal communication). High revenues from oil have induced its leadership to nurture a sort of optimism in the internal financing capacity. Moreover, since it gained power at independence, the government has always given the highest priority (being in this quite successful) to the wars it has fought. War in Angola, unlike in Mozambique, has been characterized by high technology and escalating costs. With defence getting the lion's share of government budget, during the 1990s the social sector collapsed and public services in rural areas dramatically contracted. In the mid-1990s, 30 per cent of the government budget was allocated to military expenditure and 20 per cent went unrecorded, while the provinces with two-thirds of the total population received around 15 per cent of actual expenditure (Le Billon, 2000). Outside the cities, the public sector has been able to deliver some basic services only when relying on extensive support by NGOs or international agencies, that often have assumed full responsibility, including for the payment of government officials (Christoplos, 1998).

⁷ For instance, one respondent has suggested that the introduction of UN sanctions against UNITA has been delayed because of pending transactions between the latter and certain economic groups in the US.

Table 2 UN consolidated inter-agency appeals, Angola, 1994–2000

Year	Requirements (US\$)	Commitments (US\$)	Requirements met (%)
1994	181,229,462	158,144,592	87
1995	294,326,884	145,273,539	49
1996	201,502,093	111,105,732	55
1997	198,735,512	105,953,908	53
1998	80,965,142	63,791,764	79
1999	110,840,321	96,333,290	87

Source: UN OCHA, *Financial Tracking Database for Complex Emergencies*.
http://www.reliefweb.int/ocha_ol/index.htm.

It has been argued that the government was “consciously abandoning the social sector” (Duffield, 1994a), that “hyperinflation and lack of a consistent wage policy are destroying the state” (Aguilar, 1996), with health being regarded as the most “imploded” sector among public services (Ostheimer, 2000). Cliffe and Luckam (2000) have

characterized Angola as a state ceasing to carry out its normal function of providing welfare, and abandoning its population.

The donor response to the Angolan protracted crisis has been defined as “minimalist and

Table 3 Aid per capita in selected countries, 1990 and 1998 (US\$)

Country	1990	1998
Angola	29	28
Mozambique	71	61
Tanzania	46	31
Zambia	62	36

Source: World Bank, 2000.

opportunistic” (Duffield, 1994a) for a number of reasons, namely the serious risks of failure, given the highly unstable political-military environment, the limited access and poor security associated with aid delivery, the low project implementation rate and the common perception, not without basis, that the country is rich and could meet part of the needs, if its leaders were more concerned and committed. The international response to the first donor conference on food aid, held in 1985, for an estimated affected population of half a million, and to the follow-up conference in 1988, when the potentially eligible beneficiaries had tripled, was “half-hearted and uninterested” (Ball and

Campbell, 1997). A third UN-government emergency appeal in 1989 was largely unsuccessful (Duffield, 1994a).

The lack of donor interest is also confirmed by the fact that in 1988 only six international NGOs were operating in the country (ibid.). As the Angolan crisis deepened and evidence of widespread suffering mounted, donor response became more generous, as shown by the most recent appeals (Table 2). The total requirements (US\$1.1 billion) and resulting commitments (US\$680 million), compare unfavourably with the Mozambican appeals (see Chapter 5). It must be observed, however, that a direct comparison is flawed by the different period in which the Angolan appeals were launched: after 1992, with the crisis in the Balkans, competition for stretched international aid resources was particularly strong. Actual disbursements against commitments have remained low, due to poor absorption capacity and fundamental disagreements with the IMF.

This reluctance to support Angola has also been motivated by the donor concern that, by allowing the government to release funds needed for the social sectors and to re-allocate them to military use, their aid was contributing to the war effort (Aguilar and Stenman, 1994). Donor diffidence has been compounded by the extreme weakness of the information base, partly due to widespread insecurity, which made the appeals “largely the product of guesswork” (Duffield, 1994a). However, given the disproportion existing between aid and government revenues, some observers regard donor concerns about the misuse of aid as unrealistic. Other factors, such as widespread criticism of the government in relation to civil rights, corruption, capacity and commitment, its inability to make a better case for aid, scepticism about an eventual settlement, and troubled relationships with the Bretton Wood institutions, are probably playing a more influential role in shaping donor behaviour. Additionally, security problems and political pressure from both rivals have intermittently restricted aid delivery. As a result of insecurity, aid has targeted mainly city dwellers, and has been affected by regressive patterns of distribution and frequent leakages (Sogge, 1994).

Until the mid-1980s, assistance to Angola came for the most part from Nordic countries (mainly Sweden) and Cuba, overall representing a meagre US\$10 per capita, 2 per cent of GDP (World Bank quoted in Sogge, 1994), and only half of the food aid it had requested (ibid.). These figures compare negatively with those, already low, of Mozambique during the same period (see Chapter 5). Table 3, referring to more recent years, compares ODA provided to Angola, Mozambique, Tanzania and Zambia. These figures show the very limited significance of aid in Angola in relation to Mozambique and two neighbouring countries not ravaged by conflict. Given the size of material destruction, the number of affected people and the terminal status of the Angolan economy (excluding the offshore oil component), the inadequacy of international support is clear. This sharply contrasts with donor generosity towards Mozambique, which has maintained aid inflows at roughly the same levels enjoyed at the peak of the crisis, against the steady decline of aid incurred by Zambia and Tanzania.

Ostheimer (2000) observed that in Angola giant mineral revenues dwarf the significance of aid, which becomes negligible to warring parties. While the donor community is absorbed by ceremonial events, its sense of self-importance and internal disagreements (UNDP, 2000), the

Table 4 Proportion of population living in urban areas, Angola, 1960– 1998

Year	Percentage
1960	11
1970	14
1994	43
1998	50

Source: *Nsala et al., 1998.*

crucial decisions are taken in other venues. The leverage enjoyed by donors in Mozambique is, therefore, absent in Angola. Only in circumstances of extreme crisis, such as in 1993, both the government and UNITA appealed to the donor community for humanitarian assistance, reportedly because both sides had run out of resources (Duffield, 1994a). A radical view suggests that “in the Angolan civil war the belligerents did not need the population, its existence was in fact an inconvenience for them” (Cahen, 1997). The international response to humanitarian crises would have therefore offered to contenders a convenient opportunity to disengage from their

fundamental duties towards affected populations (Tvedten, 1997). This reading is supported by the strategy adopted by UNITA of pushing civilians into government areas in 1998–99 (Prendergast, 1999; Ostheimer, 2000).

In the second half of the 1980s, due to depressed oil prices and the sharp increase in military spending, the Angolan financial situation came under strain and new donors (such as the EC) and financiers (IMF, WB, ADB, etc.) stepped in. Despite protracted negotiations, the support provided by the Bretton Woods institutions, however, remained half-hearted, consistently undermined as it was by the inability or unwillingness of the Government of Angola (GoA) to attain a measure of economic discipline and transparency. “While agreements with the IMF have been within reach at many times in the past, they have invariably slipped away” (Economist Intelligence Unit, 2000a). To this day and despite increasing oil revenues, boosted by better prices and new fields coming into production⁸, the government financial position remains precarious. Future oil production has been largely mortgaged and the debt service, estimated at US\$838 million in 2000 (ibid.) is unbearably high, due to the high-interest, short-term heavy borrowing of the past (Aguilar, 1998). Substantial internal arrears compound the problem. In October 2000, an assessment of the nine-month (IMF) staff-monitored programme highlighted serious problems, thus postponing once more the introduction of a fully-fledged structural adjustment package. Meanwhile, the increase of the budget allocation to social sectors (envisaged in the agreement with the IMF) has failed to materialise. The revised share to health for 2000 was actually reduced, from the already low 3.6 per cent to 2.8 per cent (Economist Intelligence Unit, 2000b).

Little is known about relief delivery in UNITA-controlled areas, given the limits posed by warring sides to outsiders operating in these areas. Moreover, before the Bicesse Accords, few agencies were eager to operate outside the government’s sphere, under the rebels’ strict control and in uncertain security conditions. Furthermore, the control of territory and populations has changed in the different phases of the war. Here again, rough estimates have been based on guesswork. For example, in 1996, the UN Humanitarian Assistance Coordination Unit (UCAH) estimated that around 200,000 IDPs living in UNITA areas were in need of humanitarian assistance (Ostheimer, 2000); by mid-1999, the UN estimated that two million, or 17 per cent of the total population, were living in UNITA areas (ibid.). A respondent observed that, overall, food insecurity has been less acute in UNITA than in government areas, due to the higher access to arable land in the former, and to the tight military discipline imposed on the peasants forced to cultivate to feed the movement’s elite and the army, but entitled to keep a portion of subsistence crops to feed themselves.

In the late 1980s, the ICRC and MSF-France were the only agencies providing humanitarian assistance to populations living in UNITA areas. Duffield (1994a) reported on a USAID assessment mission to a UNITA area, which confirmed the need for relief and claimed that UNITA had the structure and capacity for delivering assistance to its populations. The mission results were used by USAID to put pressure on the UN for a comprehensive humanitarian programme (i.e. not limited to government areas). Other respondents argued that the widespread positive perception of social services in UNITA areas was based on orchestrated demonstrations of good performance for external consumption.

The government relief agency, the State Secretariat for Social Affairs (SEAS), with limited resources and operational capacity, was clearly unable to manage the emergency programme, let alone meet the needs of large displaced populations. These, according to WFP, were “abandoned to its own” (quoted in Duffield, 1994a), a symptom of the structural crisis of the state. In 1990, against the initial opposition of the government, the UN launched the UNDP-

⁸ The oil production is estimated to double in the next four years (Stokes et al., 2000).

managed Special Relief Programme for Angola (SRPA), to coordinate the humanitarian response of UN agencies, mobilize funds through appeals, negotiate with the warring parties access to relief, and implement, through NGOs, an emergency programme.

The SPRA has been regarded as an unsuccessful programme: like its UN political kin, the UN Angola Verification Mission (UNAVEM) II, it was provided with insufficient resources, despite the high-profile image with which it was launched (Duffield 1994a; Ostheimer, 2000). The UN agencies collaborated only half-heartedly, maintaining their own parallel programmes. Moreover, after the Bicesse Accords, a pervasive optimism about the peaceful outcome of the forthcoming elections prevailed within the donor community (which says something about the inability of outsiders to read the Angolan puzzle correctly). Emergency-oriented instruments were therefore progressively sidelined.

Since 1989, the UN has deployed several peacekeeping missions to Angola. The first mission (UNAVEM I) had the mandate of supervising the withdrawal of Cuban troops from the country between 1989 and 1991 (within the framework of Namibian independence). Following the Bicesse Accords in 1991, a new mission – UNAVEM II – was established with the mandate of monitoring the cease-fire, the demobilisation and formation of the new army, and the elections. With a few hundred military and police observers and limited financial resources⁹, and without the power to enforce observance of the accords, the UN mission was unsuccessful, “a textbook example of how a peacekeeping operation should not be run” (Vines, 1998b).

The third war started soon after the elections, declared fair and free by international observers but rejected by UNITA as flawed. The situation precipitated in the following months, with intense fighting in Luanda and other important cities, from which UNITA was expelled. The rebel movement brought out from the bush its supposedly demobilised army and caught the government off-balance. Within a few months, UNITA managed to control three-quarters of the countryside and to occupy the symbolically charged city of Huambo. It has been estimated that in the two following years 300 000 Angolans, 3 per cent of the population, died as a consequence of the war, probably more than in the preceding 16 years of war (ibid.). By mid-1993, the UN estimated that 1000 Angolans were dying daily as a result of fighting (Lanzer, 1996).

The resumption of war and its intensity caught aid agencies unprepared, as most of them had shifted their relief programmes to rehabilitation and development at the time of the Bicesse Accords and had replaced their emergency-oriented personnel (according to the dominant continuum paradigm). A few months after the renewal of fighting, some two million Angolans were in need of emergency relief. Their number almost doubled by the end of 1994 (ibid.). The recognition of the “failure” of UNAVEM II prompted the UN to authorize a much larger operation after the signing of the Lusaka Protocol in 1994, with a military contingent of 7000 personnel, and a bigger budget. The painful lesson learned from the UNAVEM II failure also influenced the design of the peacekeeping operation in Mozambique (ONUMOZ, established at the end of 1992) which was provided with abundant human and financial resources.

⁹ “An operation done on the cheap” according to the then Special Representative of the Secretary-General (SRSG) (quoted in Munslow, 1998).

The military effort sustained by the government and UNITA totally absorbed their attention and resources, denying them the means to adequately assist the populations living in their areas. Early in 1993 both parties appealed to the international community for relief assistance¹⁰. Donor response in this case was prompt, with aid per capita increasing to US\$43 in 1994 and US\$52 in 1995 (UNDP, 1995). The UN established the Humanitarian Assistance Coordination Unit (UCAH), which, albeit reporting to the SRSG, was not part of UNAVEM; no direct operational links between the two UN branches existed. This institutional setting was different from that adopted in Mozambique, where humanitarian assistance was integrated with the other components of the peacekeeping operation. In Angola, it was thought that this autonomy would have allowed UCAH and its partners to maintain a distance from the mainly political and military mandate of UNAVEM, which was criticized by all parties for its failure to secure the implementation of the Bicesse Accords. The respective mandates of these two UN branches and their links were, however, insufficiently clarified or understood, which negatively affected UCAH's role in critical activities, such as demobilisation (Zagaria and Arcadu, 1997).

In the highly politicised context prevailing in Angola, the semi-autonomous state of UCAH had been regarded as a critical requisite for maintaining the necessary impartiality in the negotiation of humanitarian space with the government and UNITA and in representing the international community¹¹. It was also the key to its successful contribution to the humanitarian effort (Hawkins and Redding, 1996). The effective coordination role of UCAH was achieved through agreed relationships among donors, UN agencies and NGOs, and by exploiting the comparative advantage that each agency had in its own field (*ibid.*). As in the case of the corresponding agency in Mozambique, UCAH became the clearinghouse for information on humanitarian needs and interventions, a role that is usually not disputed by other agencies.

The cease-fire signed in November 1994 held, despite frequent abuses of the Lusaka Accords and sporadic fighting between the two sides. Coupled with the establishment of a government of national unity (GURN) in 1997, this ensured a period of relative stability, labelled as “no war, no peace”, until late 1998 when the country returned to all-out war. For the second time the demobilisation of the UNITA army resulted as a largely incomplete process, since it had not involved its elite troops. Nor was Jonas Savimbi more committed to the GURN, nor to the reintegration of the territory he controlled under a unified administration. As many staff experienced in relief had left the country to work in emergencies elsewhere (UNOCHA, 1999), the international community was again unprepared to redirect its rehabilitation programmes towards relief. The 2000 Consolidated Appeal (*ibid.*), with requirements of US\$258 million, was launched to assist more than one third of the population, considered war-affected. In this dispiriting context, and with decreased human and financial resources, UCAH's coordinating role has lost its shine, and many functions have been taken over by the World Food Programme (WFP), which runs the biggest relief operation in the country (covering two million beneficiaries) and can rely on strong logistic and transport resources.

¹⁰ As discussed above in this chapter, some observers considered this behaviour to indicate disinterest in social and humanitarian issues, rather than lack of resources (Cahen, 1997).

¹¹ Only the ICRC and the MSF family remained explicitly independent from UCAH and maintained separate negotiations with the two parties.

The “fourth” war continues, with the military balance decisively in favour of the government army. The events in the Democratic Republic of Congo, the growing impatience of the international community towards UNITA’s mischievous tactics, the loss of crucial airstrips and the increasing international pressure to control diamond smuggling (while oil production and export are growing steadily), are the main factors behind UNITA’s present military difficulties (Economist Intelligence Unit, 2000b). Whereas UNITA’s ability to mount conventional military operations has probably been defeated, its guerrilla capacity has remained strong, as demonstrated by recent attacks launched across the whole country.

Summing up, no short-term nor durable solutions are available to put an end to the Angolan crisis, even if a military victory of the government seems within reach. Important economic circuits, involving oil, diamonds and arms, with stakeholders operating at national and international level, are solidly in place to serve vested interests that see the continuation of war as a convenient cover for further accumulation of wealth. On the government side, the wealth coming from oil is the main force for resisting external and internal pressures for change. It is also the main reason for the successive failure of the economic reform programmes launched almost every year, but never successfully implemented¹² (Munslow, 1998). As one respondent observed, the peace process was doomed from the beginning, as the insistence on holding elections gave the impression that votes could represent a solution to old, entrenched political, social and economic problems (Berdal and Keen, 1997). It has been noted that “parliamentary elections have a poor track record in bringing stability to an already unstable and fractious situation” (Duffield, 1994a), a statement confirmed by the tragic events in East Timor in 1999.

¹² For example the Programme of Economic Stabilization in 1992, the Emergency Programme in 1993, the Economic and Social Programme in 1994 and 1995, the “New Life” Programme in 1996 (for a vivid account of the rapid turnover of these programmes, see Hodges, 2000).

5 Emergency and humanitarian assistance in Mozambique

In contrast to Angola, where three different liberation movements started fighting each other at independence, the Mozambique Liberation Front (FRELIMO) managed to maintain an undisputed leadership over competing “ethno-nationalist” organizations. The country had a window of peace soon after independence and was able to conceive and implement its policies, albeit with scarce resources and great difficulty, and to learn from their failures, before the escalating war masked the underlying causes of the problems. This empirical approach has been a strong feature of recent Mozambican history (Chabal, 2000), contributing to shaping the country’s political and economic choices, as well as those made in the health sector.

Since the first post-independence years, Mozambique relied for its survival upon aid which came in the form of import support, capital-intensive development projects, and technical assistance (Abrahamsson and Nilsson, 1995). Socialist countries made available technical assistance to support the government’s socialist options, whereas skilled workers (mainly recruited by solidarity organizations) from all over the world volunteered to help replace the Portuguese cadres who had fled Mozambique in the aftermath of independence. In the beginning, aid was limited: in 1981 it amounted to US\$170 million, about US\$14 per head, as compared to an average US\$23 for all sub-Saharan countries (Hanlon, 1991). This limited support was due to the country’s leaning towards the Eastern bloc, which upset some Western countries (particularly the US), combined with the government policy of requesting and accepting only those aid proposals which were considered consistent with its programmes, and of not encouraging the involvement of independently-minded NGOs. In fact, in 1983, a period which coincided with a severe drought (estimated to have caused 100 000 deaths) and the intensification of attacks from the Mozambican National Resistance (RENAMO), total food import, both aid and commercial, dropped in relation to previous years (ibid.).

Despite the crippling internal crisis, induced by ill-conceived policies and gross economic mismanagement, the South African apartheid regime perceived the socialist experiment carried out by its neighbour as potentially dangerous, and acted to smash it. After a few years of low-intensity warfare, Mozambique was on its knees. The year 1986 was eventful, and in many ways a turning point in the recent history of the country. RENAMO launched a major offensive in the Zambezi valley, securing its control over most of the central region. President Samora Machel died in a plane crash, the cause of which has never been clarified. The negotiations with the World Bank and the International Monetary Fund gained momentum, leading to the introduction, early in 1987, of the Programa de Reabilitação Económica (PRE) a structural adjustment programme (SAP).

The PRE was original in several ways. It was conceived by the government, without adopting the full array of measures typical of an orthodox SAP; it was launched without previous IMF approval, and it was the first experience of introducing a SAP in wartime, under conditions of extreme hardship (Hanlon, 1991). The first measures of the PRE, such as the progressive realignment of the overvalued currency to the parallel market rate and the liberalisation of prices, pleased many Western donors: food aid in 1987 doubled in relation to 1985. In the same year, the government launched with UN support the first of a long series of Emergency

Appeals¹³. It is estimated that in the six years preceding the peace agreement a total of US\$1.5 billion was pledged by donors at emergency conferences, against requirements of US\$1.6 billion (Barnes, 1998b). This achievement shows how popular Mozambique, with its policy shift from a command to a market economy and its commitment to follow the prescriptions of the Bretton Woods Institutions (BWIs), had become among Western countries.

Box 1 The *Operação Produção*

In 1983, the government, increasingly nervous about the economic crisis and spreading civil war, launched the “*Operação Produção*”, its last and most ambitious initiative to impose its social control plans. Several thousand unemployed urban settlers were deported to remote northern areas. The (poorly documented) operation represented the final blow to the FRELIMO’s socialist experiment. Its spectacular failure definitively discredited heavy-handed, top-down policies and the left-wing hard-liners who supported them, accelerated the economic downturn and, by fuelling widespread resentment, facilitated RENAMO’s ascendance. The response to this crisis was characteristically low profile, mainly managed at local level by government authorities and the Church, in line with the donor policy of refraining from intruding in what were perceived as domestic affairs. This self-inflicted emergency was however an anticipation of larger crises to come.

In this initial phase the government, supported by the block of “like-minded” donors¹⁴, which had an important influence within the international community, and by the still limited number of NGOs which included established solidarity organizations, could play a leading role in coordinating and implementing emergency relief. In this context, the attempt in 1983 of USAID to make a substantial increase in its food aid conditional to its delivery by the American NGO CARE could still be repelled (ibid.). With aid funding substantially increasing from 1987 onwards, the leading role of the government in relief coordination came under pressure, and the manoeuvring by aid agencies to gain further autonomy intensified. As RENAMO attacks in rural areas increased, the number of internally displaced persons and refugees in neighbouring countries grew dramatically¹⁵, while the lack of security hindered the distribution of relief. In 1992 only one third of the districts was accessible without military escort (Colombo, 1992). The crisis, until then construed by the government as caused by natural disasters, officially came to be called a “protracted complex emergency”, an original term introduced at the time to defuse political sensitivities, as a “neutral metaphor for civil war” (Duffield, 1994a). The political dimensions that had so far been downplayed by the government, which did not recognize RENAMO as a legitimate political antagonist and labelled its followers as “bandits”, were in this way obliquely acknowledged.

On the donor side, a reorganization had taken place. After the closure in 1986 of the UN Office for Emergency Operations in Africa, the UNDP resident representative was appointed as UN Special Coordinator of Emergency Relief Operations (UNSCERO), and a new

¹³ The Mozambican Emergency Appeals represented an absolute first in the history of emergency resource mobilization efforts, and were the predecessors of the present format of consolidated appeals.

¹⁴ Including Holland, Norway, Sweden, Denmark, Switzerland and Canada.

¹⁵ The number of beneficiaries of the emergency programme increased from 1.8 to 3.2 million between 1991 and 1992, while the refugees abroad amounted to nearly 2 million (Colombo, 1993).

emergency unit was created within UNDP, as a counterpart to the government emergency structure. The new coordination mechanism was not immune, however, from the UN's customary internal rivalries. WFP and UNICEF did not show willingness to relinquish their lead roles in relief, on the grounds of their comparatively stronger operational capacity in their respective fields, and of the lack of UNDP experience in emergency operations. Moreover, this move generated dissatisfaction within the government, which advocated the strengthening of the existing national agencies and felt bypassed by a parallel structure. If the overall coordination role of UNSCERO was disputed, some services it rendered to the humanitarian community were valuable (and were valued by other players). Assistance to the government in the preparation of emergency appeals, information gathering and dissemination of situation analyses, support to joint government-UN needs-assessment and monitoring missions were all significant contributions made by UNSCERO. In many ways these functions became the blueprints for subsequent standard operating procedures, such as the Consolidated Appeal Process.

Some bilateral donors and NGOs felt uncomfortable at being coordinated by the UN, as well as by the government. Most donors were reluctant to channel their funds through government structures, perceived at best as ineffective and inefficient (and at worst as disingenuous and corrupt), and saw UN coordination as a further bureaucratic obstacle to the speedy response to humanitarian needs. As donors increasingly opted for sub-contracting private non-profit organizations to implement their programmes, the number of international NGOs rose from 7 in 1980 to 70 in 1985 and further to 180 in 1990 (Hanlon, 1991), while national/local NGOs proliferated from 4 in 1984 to over 200 in 1996 (van Dienen, 1999).

By 1990 Mozambique (at a per capita income of US\$80) had become the world's poorest and most dependent country, with aid contributing two-thirds of its national income (Ciment, 1997). The combined effects of war, of the worst drought in the region in the century¹⁶, and of the economic crisis were leading the country near to collapse. Rural populations, hit by the severe famine, were caught in the crossfire. While the government promoted, and in many cases enforced the removal (*recuperação*) of rural populations to accommodation camps, partially in an attempt to provide security and services to them, RENAMO intensified its violent strategy with the double objective of terrorising the population and extracting resources for its own survival. It has been observed that RENAMO acted myopically, since its destruction strategy ended up damaging its own supply of war finance (Brück, 1997). The famine caused by the worsening drought and rural devastation forced RENAMO, unable to extort more resources through violent taxation or to control population movements from its areas, to accept, for the first time, a discussion on the opening of humanitarian corridors.

Since the mid-1980s, the International Committee of the Red Cross (ICRC) was the only agency providing humanitarian assistance, food aid and basic health services, on a limited scale to populations living in RENAMO-controlled areas (except for sporadic, uncoordinated and undocumented operations carried out by a few other NGOs). This asymmetry in the emergency assistance provided by international agencies was mainly due to the widespread condemnation of RENAMO as a terrorist organization, created by the Rhodesian secret services and backed by the apartheid regime in South Africa, and the donor refusal to engage in humanitarian activities outside government structures, according to the prevailing policy

¹⁶ The global cereal production in 1991/92 in Mozambique was one quarter lower than the production of the previous season, already very low.

among agencies at the time (Duffield 1998a). This perception was reinforced by the release in 1988 of a US State Department report, which authoritatively confirmed previous charges of large-scale atrocities, including systematic massacres of civilians¹⁷, attributed to the rebel group (Gersony, 1988). RENAMO had never been vocal in requesting external assistance, not fully understanding the political gains in terms of legitimization that aid agencies operating in its areas could have provided to the movement. Moreover, its lack of experience in working with international humanitarian organizations prevented RENAMO from discerning their different mandates, roles and capacities.

It has been observed that providing relief in substantive amounts in RENAMO areas might have carried the risk of “institutionalising the conflict” (Keen and Wilson, 1994) and of consolidating its position, reducing the incentive to pursue a peace deal. Relief aid became, therefore, instrumental in strengthening the government’s position, through various mechanisms: attracting populations to areas under government control, thus favouring its policy of depopulation of rebel zones; boosting its popularity through the provision of basic services; and providing indirect, if unwilling, support to the army, often involved in diversion of food aid (*ibid.*). On the other hand, lack of information makes it impossible to estimate the consequences, in terms of death and suffering, that the denial and/or impossibility of providing emergency relief have caused to civilian populations living in RENAMO-controlled areas (estimated in 1993 by UNOHAC to be inhabited by 5 per cent of the population). In fact, when these areas opened up after the Peace Agreement, their inhabitants were found to be living in appalling conditions after years of extreme hardship and isolation¹⁸.

In July 1992 the negotiation on humanitarian corridors into RENAMO areas and on securing access to all Mozambicans in need led to the Declaration on the Guiding Principles for Humanitarian Assistance, signed by both parties. This declaration, a landmark in the peace process, stipulated the impartiality of humanitarian assistance and the respect by both parties for free and safe movement of humanitarian personnel and aid goods. The declaration was not operationalized, however. RENAMO, fearing that the government could take military advantage of humanitarian corridors, advocated cross-border supplying (Barnes, 1996), and negotiations on the land routes to be utilized for humanitarian assistance dragged on, until the Peace Agreement was eventually signed in October in Rome. Even if the progressive re-unification of the country under a single administration was completed only by 1994¹⁹, restrictions to movement progressively faded away, overall security quickly improved and the humanitarian programme could expand. With hindsight, the General Peace Agreement seems to have been inevitable, despite the patent reluctance of both parties. The two rivals were exhausted, no military solution was in sight, international pressure to clinch a deal was mounting, and the most severe drought in living memory was hitting the whole Southern African region. This explains why the peace process fared surprisingly well, despite the many obstacles.

¹⁷ In 1987 the RENAMO attack on Homoine resulted in some 400 civilians killed, the single highest toll of the war.

¹⁸ As witnessed by one of the authors (AC), who participated in several inter-agency needs-assessment missions to RENAMO-controlled areas in the aftermath of the peace agreement.

¹⁹ At the time of the Peace Agreement, RENAMO controlled 7 districts (out of 128) and 58 administrative posts, an estimated 20 per cent of the entire territory (UNOHAC, quoted in Colombo, 1994b).

The Peace Agreement defined a wide mandate for the UN: to verify the cease-fire, to supervise the demobilisation of both armies, to assist the government in the preparation of the elections, to contribute to the humanitarian effort required for the return and resettlement of refugees and internally displaced people and for the reintegration of demobilised soldiers. The UN mission (ONUMOZ) was structured in four components, according to its mandates: political, military, electoral and humanitarian. Dropping the option of a separate humanitarian body (like those put in place in Afghanistan and Angola), or of a strengthened UNSCERO, the UN decided to integrate the coordination of humanitarian activities (UNOHAC) within the ONUMOZ structure. This choice reflected the activism of the newly formed Department of Humanitarian Affairs (DHA) and the need for the UN to address, with a strong and balanced peacekeeping operation, the pitfalls of previous failed missions, such as the one in Angola (UNAVEM II, see Chapter 4). This decision also underscored the political dimension of the UNOHAC's essentially humanitarian character. In the fragile and sensitive postwar context, UNOHAC's tasks were particularly complex, an aspect often forgotten by its numerous critics. They included coordinating the emergency activities of UN agencies, bilateral donors and NGOs with government and RENAMO, supporting the reintegration of demobilised soldiers, and designing and managing the mine-clearance programme.

UNOHAC was operational from the beginning, contrary to the other components of ONUMOZ, which suffered major delays. This quick start was made possible by several favourable factors: the former UNSCERO core personnel were transferred to the new structure, some UN agencies seconded their officers, and an operational budget was secured. UNOHAC's first endeavour was to develop a Consolidated Humanitarian Assistance Programme (CHAP), on the basis of the financial requirements presented to the Rome donor conference in December 1992, where US\$300 million was pledged. The CHAP for the period 1992–94 included financial requirements totalling US\$775 million, of which US\$633 million, or 82 per cent, covering both relief (distribution of food and non-food items) and the restoration of basic infrastructure and services, was committed (UNOHAC, 1994).

It has been noted (Donini, 1996) that there was a contradiction between the short lifespan of ONUMOZ and the UNOHAC's approach of reorienting humanitarian assistance to rehabilitation and longer-term development. It was clearly impossible in the two years of life of a new structure, such as UNOHAC, and in the presence of an unruly aid community, to move quickly out of an emergency-driven programme and to address long-term issues, such as capacity building and sustainability. Moreover, as UNOHAC was dominated by the political and military components of the UN operation, so were its two successive directors overshadowed by the SRSG. The pre-eminence of the political dimension of the peace process was voiced by the then US Ambassador, an influential actor in the peace process in Mozambique, and critical of UNOHAC: "In some areas, like humanitarian assistance, the less the peace-keeping operation attempts to do, the better" (Jett, 1997).

The political agenda behind UNOHAC was clear in its efforts to reorient humanitarian activities to include RENAMO-controlled areas. Initially, the facilitator role of UNOHAC in chairing a Technical Committee which included government, RENAMO, and ICRC was particularly important, given the initial reluctance and inexperience on both sides to work jointly to define needs and to programme activities. NGOs saw the UN as an impartial third party, which could also provide access to logistical means and guarantee security.

The long history of interagency competition did not cease with the establishment of UNOHAC. As funding for humanitarian assistance increased, rivalries, at times marked by acrimonious overtones, emerged within the UN family (Donini, 1996). The UN agencies endowed with operational capacity and large resources, such as WFP, UNICEF and UNHCR, felt threatened by UNOHAC's power and influence, in much the same way as they had felt towards previous attempts at coordinating activities²⁰. Many agencies, mainly those with operational capacity and experience in the country, considered coordination of humanitarian assistance as unnecessary, an obstacle to their programmes, or even an invasion of their turf.

Conversely, agencies with lesser resources but better understanding of the situation showed at the beginning more interest in collaborating. WHO for example, which was the first UN agency to second a staff member to UNOHAC, had a tradition of providing technical assistance in emergency to the Ministry of Health and UNSCERO. Before UNOHAC was set up, it had designed, in coordination with the government, RENAMO and the Swiss Development Cooperation²¹, the health component of the demobilisation programme. At provincial level, far away from Maputo politics and closer to field operations, the UNOHAC's coordination role was less contentious. There is consensus on the effective role played by UNOHAC field officers in supporting local level reconciliation (Donini, 1996). UNOHAC was successful in many instances in bringing together the government, RENAMO, UN and NGOs in order to discuss priority needs, share information, and plan and organize relief operations.

Various donors²² contributed to the establishment of a DHA Trust Fund for Coordination of Humanitarian Assistance to Mozambique. Totalling US\$32 million, the fund was managed by UNOHAC to support demobilisation and reintegration of demobilised soldiers, emergency supply of non-food relief items, de-mining and multisectoral area-based projects, which were implemented by NGOs. These locally managed funds greatly facilitated the coordination at field level and enhanced UNOHAC's image among its implementing partners. Tensions emerged, however, concerning the use of the funds for area-based programmes, in many instances creatively interpreted by the donor (Italy) as tied to implementation in areas of its own choice and/or by its home-country NGOs.

With hundreds of millions of dollars pouring into the country and a growing universe of competitive implementers²³, the pressure for mechanisms of rapid disbursement of funds often took precedence over crucial issues, such as quality, consistency, sustainability and capacity-building. The transition period witnessed the proliferation of NGOs, whose activities and role expanded, as need for assistance arose in new areas related to peacekeeping operations (such as demobilisation, de-mining, and support for elections), which were not (at

²⁰ Proof of this attitude can be seen in the reluctance of these agencies to second staff to UNOHAC. In fact, UNHCR, which had a strong international team, posted a liaison officer within UNOHAC only in mid-1993, WFP only in 1994, and UNICEF contributed with only a part-time information officer. Also, when agencies seconded their staff, they did not relinquish full control of them; therefore misunderstandings regarding staff roles and reporting duties were commonplace.

²¹ The lead agency in the health sector, and the major financier of the demobilization programme.

²² Denmark, Italy, the Netherlands, Sweden and Switzerland.

²³ The number of NGOs totalled around 250 at the time.

least in Mozambique) traditional fields of NGO intervention. The popularity and enhanced role of NGOs in Mozambique have been part of an overall trend: in the changing market of development and relief aid, NGOs have turned “from relatively independent bodies into implementers of donor policy” (Duffield, 1994b). During 1992–94, US\$180 million, or 27 per cent of the total commitments to the emergency and rehabilitation programmes included in the Consolidated Humanitarian Assistance Programme, were channelled through NGOs²⁴, in proportions that reached more than 60 per cent for health and education (Barnes, 1998a). While in 1992 the government, through its emergency agency DPCCN, distributed approximately 40 per cent of total food aid and NGOs the remainder, two years later the proportions were 20 and 80 per cent respectively (ibid.). This trend reflected both donor concerns about government capacity to implement relief programmes and the perception that NGOs could represent responsive, and also neutral, channels for humanitarian assistance.

In most situations, NGOs had budgets higher than the local government and controlled much of the transport and communication assets. This abundance of resources placed the NGOs in a privileged position: in some cases, NGOs actively tried to take over government functions, in other instances government officials, overwhelmed by NGO initiative and capacity, simply relinquished their responsibilities. It can be concluded that if NGOs have played an important role in relief, some have also contributed, together with donors, to the weakening of indigenous capacity. In many instances the state was simply replaced, or forced to play a merely symbolic role, whereas priorities were defined and decisions taken by donors, and acted upon by NGOs. Despite suffering the resource shortage, which made them unable to play their institutional role, most government officials nonetheless painstakingly re-vindicated it. They deeply resented the expanded space occupied by NGOs, and their unruly behaviour, without recognizing their contribution to service delivery. Relationships have remained strained and ambiguous to this day.

Box 2 Post-conflict rehabilitation: the UNHCR programme

UNHCR had maintained until the Peace Agreement a low profile within Mozambique, concentrating its resources in neighbouring countries, principally Malawi and Zimbabwe, which were hosting the majority of Mozambican refugees, and centralizing decision-making in its headquarters. This division of responsibility reflected the agency’s planning approach to the repatriation of Mozambican refugees, based on the assumption that the bulk of return could take place only with substantial assistance at the end of the war. The emphasis on organized repatriation²⁵ resulted in late programming: only in 1993 was a repatriation plan developed and only in December 1994 was the reintegration programme for refugees approved (Barnes, 1998c). The resources to assist in the resettlement of returnees were also transferred late to the country of origin: only by mid-1994, when the majority of refugees had returned, had the UNHCR office in Mozambique gained sufficient resources to respond to the reintegration needs (Simmance, 1996).

²⁴ This estimate is conservative, since it does not include NGOs’ own funds or other funds not reported to UNOHAC.

²⁵ Many refugees, mainly those living in Malawi, chose to return by their own means to their areas (Wilson and Nunes, 1994).

Within its reintegration strategy, UNHCR designed a massive programme of rehabilitation of basic infrastructure²⁶ at the estimated cost of US\$145 million (Marshall, 1998), to assist in the return of 600 000 refugees²⁷. Dozens of NGOs were sub-contracted to implement the programme, with almost no involvement of UNOHAC and limited coordination with the government at central level. The government agency for assistance to refugees, dwarfed by UNHCR's resources, played a very passive role, almost always limited to rubber-stamping the decisions taken by its powerful counterpart. The resource-intensive, high-profile reintegration programme of UNHCR resulted in a massive injection of resources in a short period (three years): on average, more than one new Quick Impact Project was implemented per day of its operation! The UNHCR exit strategy, based on attempts to establish linkages with developmental agencies, was conceived late and implemented half-heartedly²⁸. The wide acclaim received (and partly self-ascribed) by UNHCR is reflected in some evaluations, which stress the overall positive role of the agency in supporting the resettlement of returning refugees (Simmanee 1996, Marshall, 1998). No assessment was made of the quality of individual projects, nor of NGO performance, nor of the localisation of the new facilities. The GoM was left with many empty infrastructural shells that lacked recurrent cost financing or an appropriate service package and remained closed (Hallam et al., 1997). The huge funds absorbed by the operation could have been conceivably allocated to alternative, more productive functions. It can be questioned, therefore, whether UNHCR and other humanitarian agencies might have stuck to their mandate and competence instead of venturing into new fields, driven by donor interests. UNHCR was not alone: the European Commission financed a huge rehabilitation programme, with NGOs as implementing partners; again, coordination with the government and UNOHAC was minimal.

The role of sub-contractors also undermined NGO independence of action, as the competition for resources forced most NGOs to operate where funds were available, i.e. according to donor priorities. The considerable operational and technical freedom they enjoyed on the ground was often obtained at the expense of their passive role in strategic decisions. For instance, NGOs crowded into some sensitive but depopulated areas, high on the donor agenda but negligible in terms of the number of beneficiaries. By 1994 around 35 organizations, between NGOs and UN agencies, were active in areas previously controlled by RENAMO (Barnes, 1998a); of those, almost all (28) were running a health project (Colombo, 1994b).

Another aspect that deserves attention, is the lack of systematic monitoring and evaluation of NGO performance by their major financiers, such as the EU and the UNHCR, as well as by the recipient authorities. There are many reasons for this lack:

- the very number of projects, which made systematic evaluation extremely expensive or impossible;
- inadequate technical capacity to monitor/evaluate all the fields covered by NGOs;

²⁶ Through its more than 1400 Quick Impact Projects (QIPs).

²⁷ Additionally, assistance was provided to refugees "spontaneously" returning and to the communities where they resettled.

²⁸ For example, only few hundred thousand US\$ were set aside, after insistence of one of the authors, to cover recurrent expenditure of newly constructed/rehabilitated health units. These funds were channelled through UNICEF and not through the MoH.

- the issue of accountability, a vague concept for most NGOs which had to report to multiple partners (the beneficiaries of their projects, the host governments, their funding agencies);
- different perceptions of donors and NGOs of the primary goals of a project;
- the different reporting formats across different funding channels, even for the same donor (e.g. the EU).

The effects of NGO proliferation were even more disruptive because, contrary to other transitional countries where the government structure had collapsed, Mozambique was a weak, but not a “failed” state. It had its programmes and policies, its public sector had survived the war and, albeit amidst great difficulties, it was functioning. The government made extensive efforts to maintain the elements of a normal administration working as far as its reach and capacity went. Information was collected and published, plans formulated, negotiations with aid and development agencies held, by a government regularly stressing that it was the only legitimate ruler. On the other side, aid agencies and NGOs were keen to emphasize the seriousness of the situation and the need to act quickly and resolutely, without paying too much attention to (and often deliberately ignoring) issues as governance, administrative mandates and institutional development. The government of Mozambique was tenacious in governing the country as far as it was allowed by rebels, aid agencies and financiers (often pushing in different directions). This tenacity has paid off in some outstanding achievements, first and foremost that of succeeding in managing a structural adjustment process under extreme duress, a feat that has eluded governments in charge of stabilization programmes introduced in far more favourable conditions.

The commitment shown by the MoH in preparing plans for reconstruction (see Chapter 7) has to be considered as the action of a government willing to play its ruling role in full. Regrettably, external players were often blind to this factor. The past socialist options made FRELIMO and the government it dominated to appear necessarily evil to right-wing newcomers (who nurtured groundless hopes in RENAMO as an alternative ruler). The ignorance of the language inhibited the understanding of local realities. The scale of material destruction and human suffering masked what was functioning underneath. Only players who remained in country until and after the transition phase could appreciate (sometimes with astonishment) the relative ease with which the government took back its legitimate ruling role once the worst was over. To have preserved a functioning administration even through the depths of the crisis was crucial to recovery afterwards.

Reaching a peace settlement could not be an exclusively internal process. As war had been “internationalized” by superpowers and regional interests before, peace was heavily brokered by external actors (Cahen, 1997). The failure of the peace process in Angola represented a negative benchmark, against which the UN operation had to be planned. ONUMOZ was created on a large scale²⁹, issues of sovereignty were sometimes overlooked, externalities (such as distortions of labour and housing markets, inflation, and the related tensions) were downplayed, as a price to pay in order to achieve the short-term objectives of the Peace Agreement (Hallam et al., 1997). The success story desperately needed by the international community was bought dearly. With the benefits of hindsight, it can be argued that much of the aid provided to sustain the peace process and assist in the resettlement of returnees and

²⁹ The cost of the combined UN military and humanitarian operation between 1992 and 1994 was estimated at US\$2 billion (Hallam et al., 1997).

IDPs was “excessive” in relation to the needs. “By the time of its withdrawal, ONUMOZ had come to be perceived as a sledgehammer to crack a nut” (Hall, 1998). A peaceful environment and the willingness to recover normal life, rather than the absence of mines or the presence of a QIP, were the main motivators for hundreds of thousands of displaced civilians, who were heading back home without assistance. The fundamental misunderstanding by outsiders of the events taking place at grassroots level was patent in the design and implementation of a grossly inefficient process.

With peace consolidating, and the orderly transition to a multiparty democracy, relief activities were quickly scaled down³⁰ and donor resources shifted to developmental activities and to other countries. Since 1992, an overall decline in total aid has been registered, mainly due to a decrease in bilateral funds. The number of NGOs has mirrored the trend, declining from a peak of 250 in the early 1990s to around 150 in 1998 (van Diesen, 1999). However, Mozambique is still held in special regard by donors, as confirmed by the response to the floods, which ravaged the country at the beginning of 2000. Pledges, in excess of \$400 million, have been disproportionately generous, vastly surpassing the aid per capita provided to other countries affected by similar disasters, such as India (*The Economist*, 2000b). The donor commitment to support the Mozambican “success story” through a major crisis has partially masked the government’s poor response to the floods (The Economist Intelligence Unit, 2000a). Apparently, the experience acquired in the past in the emergency field has not been consolidated in local preparedness and response capacity. Meanwhile, evidence is mounting that “Mozambique may even have too much international assistance” (The Economist Intelligence Unit, 2000b).

³⁰ The number of beneficiaries of the emergency programme dropped from 3.1 million in 1992 to 1.8 million in 1993 (Colombo, 1993).

6 The health sector in Angola

“The tomorrow that never comes, an eternal today. So eternal that the people forget the past and say that yesterday was better than today”
Pepetela

Introduction

Given the scarcity of data and the lack of consistent time series, to assign events in the Angolan health sector to particular time periods is difficult. The picture presented below, based on data connected across different timeframes and from around the country, is therefore inevitably uneven, mainly qualitative and anecdotal.

Table 5 shows a simplified chronology, as a background and guide to the review presented in this chapter. A more detailed chronology, featuring both Mozambique and Angola, is presented at the end of the study.

Table 5 A simplified chronology of the health sector in Angola

Year	General	Health-related
1961–75	First (anti-colonial) War	
1975	Independence	Nationalisation of the Health Services
1975–91	Second War (with the involvement of South Africa and Cuba). Central planning. Economic decline.	PHC is formally endorsed, but fragments early along vertical lines. Progress is slow. Stated policies are only partially implemented. Service uptake remains low. Huge inefficiencies hamper sector development.
1991	Bicesse Peace Agreement. Political and economic reforms are slowly introduced (from 1987) but never consolidated.	Aid agencies and NGOs expand their scope and activities.
1992	General elections.	Private medical practice is allowed. Elements of deregulation emerge.
1992–94	Third War. Humanitarian emergency affecting millions of civilians. The economic crisis deepens. Hyperinflation.	Massive human losses and vast material destruction. Health services shrink to government-controlled cities.
1994	Lusaka Peace Agreement.	
1994–98	<i>No-war, no-peace.</i> Attempts to stabilize the economy abort. The informal economy expands.	Modest expansion of health services, mainly donor- and NGO-driven. Some progress in UNITA-controlled areas, where partial integration of services takes place. Rampant deregulation and privatization (formal and informal). Laissez-faire by MoH is predominant. Provinces and districts become progressively more autonomous.

Year	General	Health-related
1998–2000	Fourth War. The government gains a substantial military advantage.	Return to emergency operations in war-affected but still accessible areas. Large inflow of IDPs into government-controlled areas (by now significantly expanded).

The picture at independence

The infrastructure inherited by the health sector at independence in 1975 was very large, mainly composed of tertiary hospitals designed to serve Portuguese settlers and of facilities owned and operated by large firms, such as railways and farms. The ambitious plans conceived by the colonial masters, who dreamed of turning Angola into a major Portuguese settlement, shaped the health network as well. Oversized, high-tech installations were common, particularly in the major cities of Luanda and Huambo (whose colonial name, Nova Lisboa, is instructive in relation to these grand plans). Facilities were concentrated in urban areas, leaving conspicuous portions of the countryside unserved. The territorial fragmentation, resulting from early internal conflict among three competing parties and foreign invasion, made elusive the consolidation of the health network into a coherent system. The flight of most Portuguese skilled cadres reduced abruptly the human capital needed for operating such a large network.

From 1975 to 1992

Coverage and consumption of health services in Angola were consistently low during this period.

- In 1980, only an estimated 30 per cent of the population had access to health services (Sogge, 1992).
- In 1983, only 16 per cent of the expected deliveries took place within a health facility.
- In 1984, the coverage of DTP (3rd dose) vaccine was 7 per cent.
- Outpatient contacts declined from 1 per year per head in 1979 to 0.5 in 1983 (*Ministério da Saúde*, 1985) and to 0.4 in 1989.
- In 1991, with only 279 functioning vaccination points, immunization coverage was low, at 25 per cent for OPV/DPT-3 (Loretti, 1992).
- Standards of care were poor. An evaluation carried out in three provinces in 1990 found that “of 539 consultations observed, only 65 (12 per cent) were judged to be adequately managed” (Björck et al., 1992).

Low coverage figures contrast with the quite respectable number of health facilities (1511) reported by the MoH in 1984 (Sogge, 1992). No detailed description of this early expanding network has been found, but it seems likely that many closed facilities, or health posts providing only rudimentary curative care (such as those staffed by community health workers), were included in the count. The priority given to defence and the limited territorial control reduced the options for investing in the countryside. Additionally, the rural network suffered badly from the effects of the war. Partial data show that by 1988, only half of the existing facilities were functioning in the most affected provinces (ibid.).

Urban and hospital care attracted a large share of scarce resources. Ambitious rehabilitation plans in Luanda, such as that related to the Américo Boavida Hospital³¹, entailed huge investments. In 1989, Luanda absorbed 50 per cent of the doctors and 28 per cent of other health professionals, to staff a network accounting for 20 per cent of the total beds (UNICEF, 1991). Despite the long-lasting privilege granted to the Capital, its coverages remained very low. In 1986, only 7 per cent of the Luanda children were fully immunized (out of 87 per cent of them receiving at least one dose of vaccine) (Andersson-Brolin et al., 1991). In 1988, in Luanda City 70 per cent of deliveries took place at home (Correia de Campos, 1990). In 1989, the national average cost of fully immunizing a child was estimated at US\$60 (Andersson-Brolin et al., 1991). These figures confirm the limited attention paid to PHC and hint at the existence of vast inefficiencies.

In the late 1970s and early 1980s, the government formulated policies inspired by PHC concepts (considered robust and sincere by some respondents, but cosmetic by others)³². Relevant legislation suffered from insufficient regulations. Under-resourcing, low capacity and prevailing political and military instability, compounded by the rapid turnover of top-level managers³³, jeopardised the full implementation of those policies since their introduction. The health sector found it difficult to retain its more skilled cadres (both national and expatriate). Many important actors left the country or the sector over the years, and some were murdered³⁴. The health sector continued to be distinctively old-fashioned, hospital-centred and reliant (at least at the level of its aspirations) on the medical doctor as the cornerstone of health care provision (Ferret and Gardete, 1992; Guimarães and Saweka, 1995). Continuity of colonial patterns of health-service delivery remained strong. The Cuban model of health care, very influential at the time, accentuated the over-reliance on doctors that characterized MoH plans. The National Drug Formulary, published in 1979, contained 1300 preparations, vastly in excess of what is usually considered necessary to the provision of effective health services (Kanji et al., 1990). Without the challenge of sustaining an expansive health network, the MoH acceded to pressures from the urban elite and the medical lobby to invest in hospital-oriented care (Collard and Lapauw, 1992). Thus, no PHC-oriented categories of health workers were conceived and introduced³⁵.

³¹ The rehabilitation of this dilapidated facility, financed by the European Union, was completed in 1992, absorbing a total of US\$24 million. By 1999, according to the MoH, this facility had an output corresponding to a 150-bed hospital and no emergency services, but incurred in the costs typical of one with 1500/2000 beds (*Ministério da Saúde*, 1999a).

³² Few original policy papers were found. This discussion is based mainly on later documents referring to these early policies. According to one informant, by the end of the 1980s policy documents were virtually unavailable. The emphasis of this discussion is mainly on enforced, as opposed to stated, policies.

³³ From independence until 1995, six ministers, six directors of planning and seven directors of health services alternated in office (Guimarães and Saweka, 1995).

³⁴ Dr David Bernardino, according to many sources one of the most vigorous and influential advocates of the PHC approach, was killed by UNITA in 1992.

³⁵ In Mozambique, despite strong advocacy by the same lobbies in favour of the same hospital-oriented models, the pressure of staffing a large and heavily used network and the recognition of the reduced resources at hand forced the MoH to consider alternative and more appropriate models of health care delivery. This tension is still fuelling arguments today, causing frequent policy changes and generating gaps and inconsistencies in the workforce.

Conceptual ambiguities compounded the picture. For instance, the banning of private medical practice was not accompanied by similar measures in the pharmaceutical area, which remained fragmented and opaque (Haak, 1996). Further, community health workers (*Promotores de Saúde*) were perceived as quasi-professionals and progressively incorporated in the workforce (*Ministério da Saúde* and UNICEF, 1989a). Moreover, the training of midwives was neglected, upon the assumption that doctors would cover this area (Collard and Lapauw, 1992). Further, the seven “National Hospitals” existing in Luanda, classified as tertiary-level facilities, supposed to provide referral services to the whole network and resourced accordingly, in fact provided services corresponding to a mix of primary, secondary and tertiary care. Of the 3200 hospital beds available in Luanda in 1992³⁶, one review estimated that only 1200 tertiary-level beds would be needed (Ferret and Gardete, 1992).

The prevalent planning approach within the MoH, partly inspired by Soviet top-down models and partly inherited from the colonial past, showed curious idealistic patterns. Detailed plans, regularly neglecting to relate targets to available resources, were developed over the years, in increasing detachment from field realities^{37,38}. Ritualistic planning habits have stubbornly persisted until very recently: “the notion of a Plan may be something closer to a Directive – sacrosanct, fixed by law, intentionally over-ambitious and invariably forgotten” (Save the Children Fund UK, 1999). One respondent, well acquainted with MoH methods, reported that, irrespective of their intrinsic value, technical plans were often overruled by political decisions, usually not supported by firm financial commitments within the government³⁹.

Continuity with the colonial past was patent in the ambitiousness of the conceived projects, which, launched over the years, met with crippling difficulties, never reaching full uninterrupted functioning. Nonetheless, these endeavours diverted conspicuous resources, as well as the attention and energies of managers, away from more down-to-earth, essential concerns, such as increasing coverages, reducing inequalities and improving quality of care. Indulging in extravagant projects, the central leadership betrayed how detached from the rest of the country it had become (a point made by several respondents). Despite the painful lessons provided by these conspicuous failures, planners’ dreams ran wild even towards the end of the 1980s. A proposal related to medical training, formulated in 1989, projected the steady expansion of graduates, to reach an output of 2288 by 2011. A new medical school with a capacity of 1000 graduates a year was built with Spanish support in the 1980s (Collard and Lapauw, 1992). A new training facility for mid-level cadres to be built in Lubango, with the capacity of 350-400 new students a year, was included in the *Projecto do Sector de Saúde* (PSS), launched in 1993 and financed by the World Bank. The capital budget of the Lubango School was originally set at US\$ 9.5 million, while its recurrent costs were estimated at

³⁶ Including the 800 belonging to the Américo Boavida Hospital, at the time under rehabilitation.

³⁷ “*Dir-se-ia que existe todo um ritual de planificação*” [“A whole planning ritual seems to exist”]; “*Um hipotético planeamento ocupa mais energias que a actividade de administração corrente*” [“Imaginary planning absorbs more energy than the activities of daily management”] (Correia de Campos, 1990).

³⁸ “*on planifie au niveau central le nombre de comprimés, le millilitre de sirop et le grammes de pommade nécessaires*” [“The central level plans the number of pills, the millilitres of syrup and the grams of ointment (which are supposedly) needed”] (Duquesne and Penicaud, 1992).

³⁹ Questionable planning patterns are not restricted to the health sector: “Exasperation is the emotion which overwhelms development planners in Angola” (Christoplos, 1998).

US\$500,000 per year at its opening and at US\$1.5 million at full operation. The project was later scaled down to more realistic proportions (World Bank, 1998).

Domestic financing, nominally fairly stable through the 1980s, shrank dramatically in real terms, due to rampant inflation (unacknowledged by official statistics). From 1985 to 1989, the health budget decreased from 3.3 per cent to 1.8 per cent of GDP (Freire dos Santos and Vicente, 1991). By 1990, internal allocations to the MoH could be as low as \$0.5 per capita (Duquesne and Penicaud, 1992). Real expenditure was even lower, due to erratic budget management. The foreign currency allocation to the health sector fell from \$78 million in 1981 to \$9 million in 1986 (Kanji and Harpham, 1992). Drug imports almost halved in weight between 1986 and 1989 (UNICEF, 1991).

External assistance, mainly provided in the form of technical, specialist assistance by allied countries, such as those of the Eastern bloc (whose medical doctors numbered around 200 during the 1980s), was inadequate to fill the widening gap, particularly at PHC level. Towards the end of the 1980s, the most important donors were EU, Italy, UNICEF and Sweden, whose contributions went mainly to infrastructure, drug production and imports, and immunisations (Correia de Campos, 1990; OMS Angola, 1990; Duquesne and Penicaud, 1992). Investments were predominantly concentrated in Luanda⁴⁰. Among Western countries, Sweden was the most conspicuous partner to the health sector. However, a comprehensive, in-depth evaluation of Swedish sector aid, carried out in 1991, reached dispiriting conclusions. Support had proliferated out of control, covering several vertical programmes, which contributed to the prevailing fragmentation. Worse, most special programmes were themselves poor performers. Only the Trypanosomiasis Control Programme was singled out as successful. Frustration and scepticism dominated (Andersson-Brolin et al., 1991).

An undocumented but substantial proportion of health resources was absorbed by the army's health services, which in 1992 employed about 10 000 workers (including 240 medical doctors) and operated a hospital network of 1650 beds (Lagrange, 1992). Health services of important dimensions were provided to employees by several large state and private companies, particularly those active in the mining sector, such as Sonangol and Endiama (Duquesne and Penicaud, 1992).

The workforce of the health sector expanded during this period, through the proliferation of low-level training in all provinces. In 1987, unskilled staff comprised 60 per cent of the workforce. Of health-professional training, a large part was low-level (UNICEF, 1991), and hospital nursing remained the mainstay of the training received by most health workers. A similar growth, albeit on a smaller scale, took place with university-level training. During the 1980s, the average output of the Medical School was 45 graduates a year (Collard and Lapauw, 1992). The number of Angolan doctors enrolled in the NHS rose from 148 in 1985 to 375 in 1995 (*Ministério da Saúde*, 1998a; World Bank, 1998). This increase compensated in numerical terms for the sharp fall of expatriate doctors (from a peak of 509 in 1987 to 239 in 1995), largely accounted for by the withdrawal of Cuban and Soviet doctors that took place in 1990–91. As most of these were hospital specialists, who were replaced by junior national cadres, technical capacity within tertiary facilities was greatly reduced.

⁴⁰ Of 11 major investments financed by external sources reported for 1990, only one was located outside Luanda (WHO, 1990).

Services fragmented along vertical lines under the pressure of several international programmes, which provided much-needed resources to fill some of the gaps created by severe domestic under-funding. A study about community health workers (CHWs) and traditional birth attendants (TBAs), carried out in 1989, found command, supervision, information and supply lines of these programmes totally separated from those related to formal health services (Ministério da Saúde and UNICEF, 1989a,b). Supply lines multiplied⁴¹, information subsystems proliferated, and provincial authorities were left to survive on their own. The increased space allowed to provincial and municipal authorities by the wavering support of the central MoH was not backed by devolution of control over scarce or absent resources (Guimarães and Saweka, 1995). Peripheral managers had increasingly to rely on resources provided and usually controlled by external partners. In some cases, there were positive developments, related to issues as varied as cost sharing, reconciliation, community health workers and efficiency gains. However, promising start-ups at peripheral level consistently failed to attract the attention of central decision-makers and to be incorporated into national policies.

The pharmaceutical sub-sector suffered from lack of regulations and customary bypassing of the existing ones. Drug expenditure in 1984 was a respectable US\$2.3 per head, which is starkly at odds with the frequent and severe drug shortages reported at the time and the outpatient declining uptake (*Ministério da Saúde*, 1995). An evaluation of the Essential Drugs Programme (EDP), carried out in 1990, drew worrisome conclusions: “*Não existe uma política farmacêutica bem definida*” [“A clear pharmaceutical policy does not exist”]. The sub-sector was severely fragmented. The EDP covered only some provinces, while different aid agencies supplied drug kits of different composition. Coordination within the MoH was hindered by ill-defined roles, responsibilities and relationships. Information about drug purchasing and distribution was grossly inadequate (Kanji et al., 1990). An ambitious investment, launched in 1986 with the support of the African Development Bank, aimed to produce in-country half of the drugs required by the health sector. The two plants, located in Luanda and Benguela, opened in 1992 but achieved disappointing results. By 1994, the Luanda plant operated at 30 per cent capacity (*Ministério da Saúde*, 1995). Reportedly, the situation has not improved significantly since then.

During the peace window of 1991–92, the external presence in Angola increased dramatically. One respondent refers to more than 1000 expatriates working in the health sector at the time. Initiatives aimed at preparing the ground for postwar reconstruction were launched with donor support; for example the “*Etude de pré-investissement du secteur de santé*” was commissioned from a consultancy and funded by the African Development Bank in 1992. The study identified a number of problems (most of them discussed here) and proposed sensible measures to tackle them. There is no evidence that its results were incorporated into MoH mainstream thinking. According to one respondent, the financial-management restructuring implied by the proposals was incompatible with the practice prevailing within the MoH at the time. In any case, the recrudescence of war after the 1992 elections made impossible the implementation of the resulting plans.

⁴¹ “*Il existe une désorganisation totale du système d’approvisionnement en matériel et médicaments*” [“There is a total disorganization of the drug and equipment supply system”] (Lagrange, 1992).

From 1992 to 2000

The collapse of the peace process in 1992 marked a corresponding turning point in the health sector. Amid the difficulties experienced by the public sector, collection and use of routine data deteriorated. Documents become scarcer and data more problematic and tracking developments from this time is difficult. Agencies and NGOs produced a disparate array of data, aggregated analysis of which is impossible. The prevailing atmosphere of mistrust reduced the circulation of documents and the sharing of experiences. By the end of the decade, crucial information was missing or lost.

The 1992–94 “war of the cities” inflicted heavy damage on facilities in important towns, such as Luanda, Huambo and Kuito. During the ensuing “no-war-no-peace” period, capital shortage and the prevailing climate of disbelief in relation to the eventual outcome of the peace process discouraged rehabilitation activities, which kept a low profile. Combining the effects of lack of maintenance with war damage, health facilities now require replacement more often than rehabilitation. The reconstruction of large hospitals to emulate pre-existing plans might absorb huge capital and strengthen the already heavy urban bias, starving the PHC network of available resources and denying it any chance of being revamped. Conversely, the vast material destruction of the 1990s offers a unique opportunity to reshape the sector on more efficient and equitable grounds.

Internal under-funding exacerbated other problems, and investment became negligible. In 1995, only 6.5 per cent of the MoH budget was allocated to drugs and medical supplies (World Bank, 1998). Bouts of hyperinflation led to huge oscillations of actual financing. However, internal under-funding ought to be qualified. In 1996, public internal expenditure on health was estimated at US\$6.3 per capita, a quite respectable figure when compared to those of many neighbouring countries (*República de Angola* and UNICEF, 1998). The meagre returns provided by the health sector in terms of coverages and service volumes against this level of funding confirm the existence of huge systemic inefficiencies. The pervasive scarcity of drugs, for instance, is more likely explained by fragmentation, misallocation and wastage, than by absolute under-funding. A 1995 report estimated that pilferage might account for 70–80 per cent of the total essential drugs purchased (Johansson, 1995). An eloquent example of inefficient and inequitable allocation of resources is the large share of state funding (15 per cent in 1994) attributed to medical referrals to foreign hospitals (Hodges, 2000).

These multiple distortions resulted in the dominance of external actors in the programming, and of external resources in the implementation of health activities. Available data (*Ministério da Saúde*, 1998a) point to an average annual external financing of US\$23 million (or about \$2 per head) during the period 1990–93. This is a low level of funding, both in absolute terms and compared to other African countries (where figures of \$3–5 are more common). The extremely low absorption capacity affected all initiatives and had certainly been influential in keeping external resources at such low levels. Between 1992 and 1996, actual expenditure averaged 76 per cent of the allocation foreseen in the state budget (*República de Angola* and UNICEF, 1998).

Private medicine was allowed by new legislation in 1992 and expanded dramatically over the years in urban settings in an increasingly deregulated way. In 1999, a thorough review found 476 private facilities operating in Luanda and employing 2659 health workers, mostly on a part-time basis. Of these facilities, 29 were operated by religious organizations (*Ministério da*

Saúde, 1999a). Ambiguous situations, where health professionals belonging to the public sector also work in private facilities, or charge patients directly even in public facilities, have become very common. Several pilot projects (mainly backed by NGOs) have tested different cost-sharing approaches, triggering a high-level debate. In 1998, the government endorsed the principle of cost sharing, without issuing tariffs and guidelines.

Box 3 Health services in UNITA areas

Information on health services in areas controlled by UNITA is scarce and controversial. Respondents reported a broad range of positions, from the fervently positive to the plainly dismissive. MSF-France was outspoken in its praise of UNITA health services, without, however, providing supporting evidence (Sogge, personal communication). There is consensus about military health services, considered to have been well equipped and well supplied (by South Africa during the 1980s), but accessible only to soldiers and to the party's elite (whose members could be referred to Kinshasa when necessary). Services for civilians, provided in mud-and-pole posts staffed by "nurses" with only rudimentary training, tended to be primitive. The over 700 health facilities boasted by UNITA in 1989 (Sogge, 1992) were likely to belong to this category. According to one informant, in 1995–97 in Northern Angola, "In each village there were health posts with very little drugs". In Huambo province in 1996–97, another informant found UNITA health workers "who attended seminars keen to learn, desperate amateurs and long-suffering". Informants who worked in UNITA areas during the period of "no-war-no-peace" found health managers collaborative and interested in service delivery, but submitted to tight control by their political-military overseers.

"Early 1998 had many UNITA "nurses" working in government hospitals [in Benguela and Huambo provinces] under integration plans". Several respondents were impressed by the joint health activities taking place at grassroots level and by the mutual recognition that "the devils did not have horns". Unfortunately, this quite intense integration around practical issues did not influence the views of top leaders. Other respondents were more sceptical about UNITA health services: "UNITA excelled in the organization of demonstration units for international consumption"; "health services were generally applied as instruments of control". Iron discipline is a recurrent theme when referring to life in UNITA areas. This capacity to force people to participate in health-related activities was highly praised by health operators (mainly belonging to NGOs), particularly when contrasted with the customary muddle prevalent in government areas. Apparently, the authoritarian side of these public health "successes" was overlooked.

After the Lusaka peace agreement, external support to UNITA areas increased. Whether donor resources were fairly apportioned between the two sides is arguable, given the different status of the two administrations, the size of the populations living in the respective areas and the health networks to be supported. Respondents agreed that external resources went mainly to the government health sector, with a proviso. Whereas government authorities looked prepared (even eager) to delegate responsibilities for service provision to external partners, UNITA made efforts to assert itself as the legitimate service provider in the areas of its control. Despite this posture, once confronted with the task of managing urban, formal health services, as during the period when it controlled Huambo City, UNITA demonstrated its limitations (or its disinterest, according to some informants).

The central MoH was affected by serious dysfunctions (Feret and Gardete, 1992), leading to the progressive weakening of its links with peripheral authorities. “*Em suma, a acção sanitária do MINSA não obedece a nenhum mecanismo de planificação nem de avaliação*” [“Concluding, the MoH health action does not follow any planning or evaluation mechanism”] (Guimarães and Saweka, 1995). The appointment of a Minister of health belonging to UNITA (contemplated by the Lusaka Peace Agreement but already envisaged before it) was interpreted as due to the ruling party’s disinterest in health-related issues, thus further undermining the already low profile of the health sector. As this position was left vacant until 1997, the damage done was even more conspicuous. One informant stated that the MoH performance was shaped by “a continued obsession with form over substance, vertical over horizontal and the mindset that renaming and fiddling with titles solves things”.

Important agencies tried to fill the policy vacuum by supporting ambitious projects (all including a component of policy formulation) at central level. Thus, the World Bank financed the PSS, the EU was behind the Post-Emergency Health Project and DFID supported the Health Transition Project (which included WHO). Despite a number of significant achievements, no project was able to revitalize the policy discussion to the point of enabling the MoH to formulate workable health policies. The substantial overlap existing among these three projects demonstrates the persistent inability to coordinate initiatives, which jeopardises donor action. Policy proposals remained as such, lacking approval or resolute implementation.

By the end of the century, characterising existing health policies had become distinctly difficult. To understand the roots of this policy vacuum, we have to consider not only the lack of leadership at central level and the delusions of the past, but also the weak information base (Guimarães and Saweka, 1995) which has contributed significantly to the present picture and explains the tentativeness of virtually every available document (see, for instance, *Ministério da Saúde*, 1998a). From the perspective of field workers, national policies have become virtually invisible. Provincial and municipal officials routinely complain about lack of central guidelines on the most diverse issues. As a respondent posted at provincial level put it, “Policies are inaccessible, undistributed, impenetrable jargon based on idealised memories of the once-existing service.” Only some vertical programmes maintain productive relationships with peripheral bodies. Nowhere are the lack of a clear policy and the inadequate enforcement of the existing relevant legislation⁴² more evident than in the pharmaceutical area, with deregulation attaining extreme levels. Whereas in this area the MoH has shown a commendable lucidity in spotting the main existing problems, to correct them seems a formidable task, given their inveterate roots, the existing low technical capacity and the big interests at stake.

The worsening of the crisis after the restarting of hostilities in 1992 saw a massive inflow of international NGOs and the proliferation of indigenous ones, allowed by law in 1992 (Birch, 1998). In 1997, an estimated 150 NGOs were active in the health sector (WHO, quoted in Birch, 1998). Of these, fewer than half had formal agreements with the MoH. The relationships of the public sector with these newcomers to the health scene have been uneasy. The old diffidence, based on ideological arguments, has been strengthened by suspected sympathy towards UNITA, by the autonomy enjoyed by most agencies, by difficult dialogue

⁴² defined as “*incipiente, insuficiente, imperfeita e desajustada*” [incipient, inefficient, flawed and ill-adjusted] by a thorough review (*Ministério da Saúde*, 1995).

and by the wide resource gap dividing public authorities from NGOs⁴³. The total dependence on external resources constrains officials from publicly venting their resentment, which nonetheless prevents them from adequately tapping NGO resources and capacity to reduce fragmentation. Periodically, attempts at coordinating players take place (particularly at provincial level, where NGO presence is more visible), without registering much progress. Health authorities need to revisit their stance towards NGOs and devise new forms of partnerships. A few promising initiatives demonstrate that collaboration is indeed possible, when backed by competence, frankness and goodwill (Save the Children Fund UK, 1999).

During the 1990s, the workforce expanded dangerously, incorporating new trainees not needed by a sector whose coverage and output were stagnating or even contracting (*Ministério da Saúde*, 1995). Overcrowded and under-resourced training facilities (Collard and Lapauw, 1992) churned out health professionals whose skills were grossly inadequate and quickly deteriorated once deployed to dilapidated, overstaffed and poorly managed health facilities. The efficiency of the training network can be inferred from consideration of student turnout. During the period 1989–1998, training institutions reported 28 151 enrolments against 9 966 students (35 per cent) completing the course (*Ministério da Saúde*, 1999b). The number of Ministry of Health employees, estimated at 24 000 in 1987 (UNICEF, 1991), rose to 36 500 in 1998 (*Ministério da Saúde*, 1999b). This bloated and unproductive workforce concentrated in urban areas, due to security concerns and to the closure of peripheral facilities. Lack of investment in rural areas made it impossible to correct this situation.

The situation worsened over the years. In 1997 it was estimated that 50 per cent of all health workers in Angola were concentrated in Luanda (Nsala et al., 1998), up from 31 per cent in 1989 (UNICEF, 1991). A recent survey in Huíla province found that health posts outside the main town were staffed only with CHWs, TBAs and unskilled cadres (*Ministério da Saúde*, 1999c). In 1997, only 5 per cent of the skilled workforce had university-level training. The skill mix of the workforce remains distorted, with a dominance of hospital-oriented cadres. The number of midwives, at about 500, is grossly inadequate. Even without adopting the WHO standard, which would recommend a 5-fold increase for these cadres, a substantial investment in their training is needed to expand access to maternal care (*República de Angola* and UNICEF, 1998).

Box 4

Reconciliation around a health problem: the special case of trypanosomiasis control

In Northern Angola, Human African Trypanosomiasis (HAT) is a serious health problem. Control activities date from the colonial era, when surveillance and regular screening covered most inhabitants at risk, thus making the settlement of large populations possible. The incidence of trypanosomiasis in Northern Angola was reduced to 1 per 100 000 in 1973. Although data from the late 1970s to 1995 are incomplete, WHO estimated in 1995 that there were more than 100 000 cases in Angola, making trypanosomiasis again the leading cause of death in some parts of the Northern Provinces.

During the period of “no-war-no-peace”, the pressure of responding to the increasing levels of the disease induced a working collaboration between the two hostile sides. UNITA

⁴³ For instance, only 1–2 per cent of the needs of the Kuito hospital were reportedly covered by the MoH (Stokes et al., 2000).

officials (including the military) were concerned about the disease and made serious efforts to facilitate control activities. Whereas NGOs and the UN had to leave on several occasions, the Church was the only institution with a continuous presence in the whole region, able to mobilize international support through its humanitarian network. In coordination with the Angolan Trypanosomiasis Control Programme, Caritas established treatment centres in 1995 in both UNITA and government areas. Several other international NGOs became active in trypanosomiasis control activities. A forum was established in which involved organizations, NGOs, UCAH and UNITA health officials collaborated under the technical authority of the Angola Trypanosomiasis Control Programme. This constructive cooperation resulted in the treatment of thousands of patients. Caritas alone treated almost 5000 sleeping sickness patients (80 per cent of them being late-stage patients) during 1996 and 1997, screening over 32 000 persons in its four treatment centres. The programme's vertical nature, detached from standard health authorities, may have boosted delivery capacity and added a veil of neutrality to these activities, therefore facilitating this collaboration.

Government and particularly UNITA authorities in the countryside were confronted with entire villages dying from HAT. Many of the professionals on both sides had been serving together in the Colonial Trypanosomiasis Control Mission. This, combined with the awareness that HAT had been successfully controlled in the recent colonial past, may explain this success story during the window of no-war-no-peace. Nonetheless, it confirms that at ground level the rapprochement of old foes around a common health problem is indeed possible.

With the collaboration of Dr Markus Behrend

In 1994–98, during the period of no-war-no-peace, some progress (although difficult to quantify) was registered at the grassroots level, as donor agencies and NGOs supported rehabilitation and training. In the same years, positive signs of collaboration between the two sides, brokered by UCAH, were reported (Zagaria and Arcadu, 1997). MoH technical guidelines, including those related to the health information system, were discussed with UNITA health authorities, becoming part of the health component of the demobilisation programme. A tripartite technical committee (involving MoH, UNITA and UN) was set up for the reintegration of UNITA demobilised military health personnel and civilian staff into the NHS, leading to the assessment of the technical and juridical requirements of hundreds of UNITA health workers. All these activities contributed positively to building up a climate of confidence and collaboration between the parties. Once more, however, political and military priorities prevailed over this promising process, which did not come to fruition.

Service coverage expanded modestly and slowly in both government and UNITA areas. Imbalances remained huge: in 1996, 90 per cent of the health service output of Huambo province was concentrated in Huambo City, whose coverage of MCH services stayed very low (Pavignani, 1997). Large hospitals continue to siphon off most available drugs, leaving the peripheral network unsupplied (*Ministério da Saúde*, 1995). Fragmentation along vertical lines proceeded further. Vertical programmes, introduced with the stated aim of giving special capacity to the corresponding priority activities, proliferated over time, as every conceivable activity was taken in charge by a special programme. Whether all these programmes were endowed with extra capacity is debatable. By now, many special programmes look rather virtual, following the rule of “no-special-input-no-special-output” (and sometimes no output at all). The result is a management structure unable to function by design (Pavignani, 1999). Geographical fragmentation proceeded apace too: whereas the

districts supported by strong NGOs could enjoy fairly good health services, others were neglected. Fragmentation also prevailed in the pharmaceutical area. By 1999, several mechanisms aimed at supplying PHC facilities with essential drugs were in place. Consolidation was badly needed (Haak, 1999).

It is not surprising that the lasting predicament of Angola, coupled with the chronic disruption of its health services, has had a profound impact on health status. With mass population displacements and lack of security hindering the ongoing polio eradication campaign, one of the worst epidemics of the disease since the resumption of the conflict broke out (Brown, 1999). No reliable data exist on the prevalence of sleeping sickness, but it is known that the disease, which had almost vanished from Africa in the 1960s, is raging in Angola and in other war-torn countries⁴⁴ (Barrett, 1999). A severe outbreak of pellagra was reported in Kuito (Baquet et al., 2000), while severe malnutrition has reached rates as high as 40 per cent⁴⁵ (Moszynski, 2000). Mortality rates above emergency-threshold levels have been reported⁴⁶ (Stokes et al., 2000). While new emergencies attract media attention and donor purses worldwide, Angola, with its structural and intractable problems has become a “forgotten emergency” (Chelala, 1999).

During the last few years, the MoH has made efforts to sketch the future of the health sector, producing interesting documents (*Ministério da Saúde*, 1998a; 1998b; 1999a; 1999b), which may signal a more proactive, forward-looking stance. These papers present a realistic analysis of the sector’s main problems, putting forward several sensible measures to address them. Unfortunately, these documents fail to translate the proposed measures fully into quantitative goals, as well as to work out the implications of most measures, particularly in terms of their cost. Once completed and approved by the government, these plans will have to pass the real test of implementation, which so often in the past has eluded planners. Whether they will be able to mobilize the necessary commitment to overcome the huge hurdles they will meet remains to be seen. Given the seriousness of the problems to be addressed and the related sensitivities, progress in human resource development and in the pharmaceutical area (where the proposed plans look promising and fairly mature) could be taken as a reliable benchmark, against which to assess the government resolve and capacity to proceed with structural reforms of the health sector.

Concluding Remarks

Through the ups and downs of war and peace, the Angolan health sector has shown an unmitigated downward trend. Rather than responding to the challenges posed by the war by formulating innovative approaches to health care delivery, the health sector passively withdrew from its responsibilities, collapsing under its own weight. The considerable ingenuity shown by field workers in delivering health services despite a forbidding environment (Christoplos, 1998) has remained untapped at national level. The big structural flaws that affected the system since independence, never tackled directly, over the years grew to reach dramatic proportions. To correct this requires a huge investment and painful measures, carefully sustained over a long period and backed by uncompromising political support. No single measure can be effective against such a desolate landscape, yet an

⁴⁴ Southern Sudan, northern Uganda and DR Congo.

⁴⁵ Currently only 4 per cent of the land is estimated to be cultivated because of fighting and widespread mines.

⁴⁶ Daily crude mortality rate of 1.7 per 10 000 and under-5 mortality rate of 4.3 per 10 000 per day.

ambitious, comprehensive, radical reform package, which is likely to be proposed by donor agencies if peace is eventually ensured, is also unlikely to succeed. Rather, a slow, composite array of modest but realistic measures, introduced from different perspectives, aimed at raising basic functions up to minimum levels and sustained over a long period, is required.

As the formulation of realistic policies, consistently implemented over time, is the crucial prerequisite to attract donor commitment, policy dialogue and coordination, aiming at re-engaging the Angolan Government with the health sector, is paramount. External support would be instrumental to finance a number of initiatives in key areas, such as the following.

- Management and financial systems (including information) should be strengthened, to spot the vast inefficiencies, correct them and attract additional resources to complement the present meagre ones. Given the limited absorption capacity and the lack of clarity in relation to how to move forward, the sudden availability of additional resources, as envisaged in the ongoing agreement with the IMF, is unlikely to be beneficial and, by stimulating further wastage and poorly conceived initiatives, could even be counterproductive. Additional resources should be released against concrete measures aimed at reducing inefficiencies, rationed in order to tackle existing inequalities and targeted to functional areas where they can make a difference.
- Training (particularly in-service) should be directed at restructuring, upgrading and streamlining the dilapidated workforce. This is a precondition to the redeployment of available staff and to the improvement of the quality of provided care.
- Investment should be focused at PHC level in neglected areas, according to a national framework aimed at reducing existing inequalities in service provision, and synchronised with other necessary actions. To revamp the derelict network will entail huge investments, difficult to quantify given available information⁴⁷. A realistic investment plan, to be conceived as soon as possible in collaboration with development partners, is a vital step in the long-term recovery of the health sector. Given the apparent past difficulties experienced by external agencies in understanding the Angolan situation, and the poor record of the same agencies in the Mozambican reconstruction (despite the availability of better information and robust plans), an explicit policy to help outsiders to find proper roles in post-conflict Angola is crucial.

⁴⁷ For comparison, in Mozambique, where building costs are lower, facilities are smaller and expectations more modest, reconstruction costs have been estimated at about US\$500 million.

7 The health sector in Mozambique, through war and recovery

Introduction

Table 6 shows a simplified chronology, as a background and guide to the review presented in this chapter. A more detailed chronology, featuring both Mozambique and Angola, is presented at the end of the study.

Table 6 A simplified chronology of the health sector in Mozambique

Period	General	Health-related
1975	Independence.	Nationalisation of health services.
1975–82	Central planning.	Health expenditure increases significantly. Primary health care (PHC) is adopted and coverages and outputs expand. This expansive thrust suffers from inadequate management capacity and capital shortage.
1982–85	Economic crisis and escalation of the civil war.	Internal financing is reduced. The National Health Service (NHS) becomes a military target. Access to basic services contracts.
1985–89	Emergency: war, famine, epidemics, and drought. Structural adjustment (launched in 1987). Donor dependence: aid agencies and NGOs pour into the country and take the lead.	Fragmentation of health services along vertical lines. Proliferation of emergency-oriented projects. The NHS, struggling for survival, becomes largely dependent on external aid for its basic functioning.
1990–92	Peace negotiations.	MoH prepares plans for reconstruction. Sector budget support to provincial expenditure is introduced.
1992	Peace Agreement.	
1992–94	Transitional period; progressive unification of the country under the same administration.	The rehabilitation of the health network starts. Health services return to previously closed areas. Private practice is reintroduced.
1994	First democratic elections.	
1994–99	Progressive normalisation, economic recovery under free-market principles. Decentralization is endorsed by the government and slowly introduced.	Reconstruction and expansion of the NHS. Skilled health workers (previously concentrated in secure areas) are re-deployed. More qualified and appropriately trained professionals gradually replace unskilled or low-level workers. Original tools to manage external resources are introduced. Elements of deregulation emerge. The formulation of a new comprehensive health policy is debated without much progress.
1999	Elections: the ruling party is returned to office.	
2000	Cyclones and severe floods devastate swathes of the country.	Large inflow of relief resources.

Source: modified and updated from Pavignani and Durão (1999).

From independence to peace, through economic crisis and war: 1975–1992

At independence in 1975, the new government made health care a cornerstone of its political agenda, and launched an ambitious sector programme (*Ministério da Saúde*, 1979).

- All existing health assets were nationalised within a unified health system, whose dominant approach was primary health care (PHC).
- To support the growth of the peripheral network and of PHC services, health expenditure expanded. The health workforce increased significantly, through the creation of new PHC-oriented professionals and accelerated training activities.
- An innovative drug policy (Barker, 1983) was introduced.
- A mass immunization campaign was successfully launched.
- The coverage of comprehensive, integrated basic services increased substantially (Walt and Melamed, 1983).

Successes notwithstanding, these efforts were undermined by serious drawbacks. The inherited network, result of the merging of a disparate array of health facilities (previously owned by agricultural estates, the army, missions, disease-control programmes and private operators) was seriously flawed. The efforts made by the MoH to rationalize the health network, reclassifying many facilities and building new ones, were only partially successful, due to the dramatic capital shortage which affected the post-independence years. Large imbalances in service provision between urban and rural areas, as well as inequalities between different parts of the country, were only partially attenuated. The referral and support systems remained underdeveloped, leaving the expanding peripheral network weak. The under-resourced training network produced mainly graduates of low professional level, who, inadequately supported, delivered low-quality care. Further, many vigorous initiatives at most levels of the NHS were thwarted by inadequate management capacity.

The ambitious plans, conceived in the enthusiastic context of independence, consistently exceeded available resources and implementing capacity, making the NHS over-stretched and ultimately unsustainable. The national context, despite the collective enthusiasm raised by the end of colonial rule, was dire: poor infrastructure, severe shortage of skilled cadres⁴⁸, low educational levels, decades of cultural isolation, and severe economic dependence on neighbouring countries. The new government's drive towards modernisation was thus based on very weak foundations, and the expected benefits failed to materialise.

War exacerbated the existing problems in the sector, and brought additional ones. Given the central position of health in government policy, and the sector's high visibility, the insurgent army consistently targeted the health system where it was more vulnerable, i.e. in rural areas, thereby wiping out past gains and strengthening the prewar urban bias (Cliff and Noormahomed, 1988), a pattern common to other countries (Macrae et al., 1996). Health workers were murdered and kidnapped, and much of the rural network was destroyed⁴⁹. Endangered supply lines became unreliable and prohibitively expensive. The already weak referral and supervision systems broke down. The health network shrank to a cluster of

⁴⁸ Of the 550 doctors in 1974, 85 per cent left immediately before or in the aftermath of independence (Walt and Cliff, 1986).

⁴⁹ Between 1981 and 1988, 291 health units were destroyed and a further 687 looted or temporarily closed (van Diesen, 1999).

facilities, mainly large, located in secure areas and defended by the army, and overstaffed, as health workers, like the ordinary population, concentrated there in search of safety.

As the deepening economic crisis reduced state revenues, the lion's share of which was absorbed by defence, allocations to the social sectors progressively declined, undermining health workers' morale and starving health services of essential resources. Between 1980 and 1989, government spending on health fell by nearly 40 per cent in real terms, while external aid progressively increased. By the mid-1980s, the NHS had become totally dependent on external aid (Noormahomed and Segall, 1992). As the support provided by the Eastern bloc decreased and Western donors became prominent, the government reconsidered its political and economic choices, switched alliances and endorsed Western economic models.

The last years of war (from the mid-1980s to 1992) were dominated by emergency-oriented activities, as many agencies, largely uncoordinated, started operations in the country. The health sector was flooded with "easy" money, which stimulated inefficient approaches to service delivery. Large agencies managed significant amounts of relief funds and became the main financiers of NGOs. Under the pressure of speeding up activities, funding criteria were relaxed. Summary proposals were approved rapidly and after only superficial scrutiny. Monitoring and evaluation of funded projects were even more superficial, or non-existent, as the management capacity of both donors and the MoH was overwhelmed by a myriad of projects. Investments benefited safe areas, such as towns or transport corridors, which enjoyed special protection, making imbalances worse. Health services split along vertical lines, according to donor-controlled programmes. Thus, support systems multiplied: for instance, the average PHC facility could be supplied with drugs by up to six different schemes. At the beginning of the 1990s, the MoH, feeling unable to cover the whole country, encouraged some major donors to "adopt" provinces, where they concentrated substantial resources, at times becoming the de facto authorities in the targeted areas.

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Substantial funds poured into the country, consistently bypassing the government, which was not adequately informed about the investment decisions of funding and implementing agencies, but was nevertheless expected to supply, staff and shoulder the recurrent costs of unplanned facilities. Often, the MoH saw its role limited to the formal approval of projects, whose adequacy and quality had not been seriously scrutinized. Few professionals expressed concern about the future sustainability of a system dramatically doped by external assistance. In the uncertain political future of the country, some agencies with a "neutral" humanitarian mandate questioned the legitimacy of the government and delivered aid only through non-state agencies.

The nature of NGOs changed: instead of channelling home-country assistance and integrating their actions into the NHS, as they had done previously, they launched independent and self-contained projects, each with its own staff, supplies, budget and logistics. To finance these large projects, NGOs competed for emergency funds controlled by multilateral agencies; furthermore, to secure funding, they also ventured into new fields, such as rehabilitation, where they often lacked a clear mandate and adequate expertise. As their autonomy from the Ministry of Health increased, NGOs went where the donors wanted them to, not where the needs were greatest. Donors' choices were often influenced by their own political priorities, which prevailed over health-related ones. Not many decisions were evidence-based, as most players were collecting information but none was able to aggregate the resulting data into a coherent picture. As a result, NGO distribution was uneven, driven as it was by operational convenience or political expedience. This resulted in overcrowding of initiatives in some

areas, such as Maputo Province, Manica and Sofala, and neglect of others, such as Cabo Delgado, Niassa or Inhambane. The inequities generated by this questionable distribution of inputs are still visible today.

The role of the Ministry shrank, as it concentrated on crisis management. By the end of 1989, the MoH leadership, supported by WHO and the World Bank, launched an ambitious exercise⁵⁰ to prepare plans for reconstruction. An important feature of the initiative was that most of the involved cadres were well acquainted with the health sector, having worked in it over long periods. That gave them a historical perspective, an acute awareness of the system's weaknesses, of the mistakes made in the past, as well as a better insight into the challenges for the future. Most of them were convinced that the health sector would have needed major changes even without the war, which provided nevertheless an opportunity to take a fresh look at the whole system. On the negative side, none of them had been confronted by the enormous challenges of a reconstruction process. Inputs from outsiders were limited, and no advantage was taken from lessons learned in other countries, such as Uganda (Macrae et al., 1993), which had gone through similar reconstruction experiences.

Indeed, because of the extreme uncertainty of the situation, the initiative was received with scepticism by many observers. Despite these fears, the planning process went on. The information system was redesigned and strengthened, and a limited but solid information base was assembled, permitting sensible policy discussion and allowing for better decision-making (Weimberg and Simmonds, 1995). Frameworks for postwar rehabilitation were completed by 1991–92, before the peace agreement (Noormahomed and Segall, 1992; Ministry of Health, 1992). Reconstruction plans stressed equity, affordability and sustainability, making clear that reconstruction would take place within a serious shortage of domestic resources, and a heavy external dependence. Plans were realistically tied to the resources expected to be available in the postwar period, thus attracting considerable donor interest and support. Furthermore, the planning exercise kept a small core of central officials and analysts concentrated and busy during a period of military and political stalemate, contributing to a relatively high morale within MoH and avoiding the loss of qualified, key persons.

Box 5 UNOHAC and WHO

In the politically uncertain postwar environment, UNOHAC was instrumental in facilitating the dialogue between the MoH and RENAMO health authorities. A tripartite technical committee was set up to share information, to plan joint need-assessment missions and to operationalise the health component of the demobilisation programme. WHO offered collaboration to ONUMOZ, taking responsibility for health care in demobilisation and seconding a medical officer to UNOHAC. As with other UN agencies, contrasts emerged regarding the reporting duties of the seconded health coordinator. A lesson learned was that the formula of secondment, and more in general inter-agency coordination, cannot be effective, if it is not supported by clear lines of command and delegation of authority. The manoeuvring related to the UNOHAC position, programme and activities was largely confined to the donor community and barely known by officials at the MoH, possibly

⁵⁰ PRAAPNS, *Projecto de Revisão de Alguns Aspectos da Política Nacional de Saúde*.

because humanitarian assistance was often equated with food aid, demining and demobilisation / reintegration of soldiers.

Also controversial was the health component of the demobilisation programme, managed by the ONUMOZ Technical Unit, with strong WHO technical and financial support. WHO subcontracted 12 international NGOs to deliver PHC to RENAMO assembly areas (AAs), while government military health personnel were provided with incentives and supplies to deliver the same services in the government AAs. Security problems occurred in some RENAMO AAs, fuelling NGO complaints of not enjoying the same protection as the UN personnel operating in the same areas. Coordination of activities also proved difficult in the subcontract arrangement, with differences emerging between some NGOs and WHO in relation to the policies and guidelines to be implemented. Other NGOs felt uneasy with their involvement in the demobilisation process, which they viewed essentially as a military operation (Barnes, 1998a). Contrasts also emerged between WHO and some NGOs regarding the allegedly weak operational and administrative capacity of the contracting agency. Many difficulties were inherent to the highly sensitive political dimension of the programme, which imposed continuous trade-offs.

On the other side, the role of the WHO country office in those years deserves comment. Even with limited resources, WHO had played a central role in the field of health emergency since the late 1980s. Its technical prominence and its promptness in seizing the opportunities offered by the transition period explain its success in mobilizing resources after the peace agreement. Unfortunately, this comparative advantage was not sustained by the country office, nor by headquarters. An external evaluation concluded that after the peace agreement “WHO missed the opportunity to be a vital part of the reconstruction and development process in Mozambique, to be a valuable contributor to future health policies and plans and to play an important advisory role at a time of great need” (Marsch et al., 1997). Within the health sector, there was consensus that these negative remarks were directed to the former WHO Representative (WR), whose performance was judged as flawed. The most vocal critic of the WR was the MoH, which on more than one occasion unsuccessfully sought his removal by Geneva headquarters. The agency’s persistence in supporting its top manager, despite his inadequacy, was particularly ominous, given WHO’s privileged position in a strategic niche within the peace process.

Outside the inner circle of decision-makers and experts involved in the planning exercise, the views commonly held were rather naive. A pervasive misconception, put forward by many, particularly at the beginning of the reconstruction process, was the stated goal of re-establishing the prewar situation, disregarding the changes that had occurred and thereby perpetuating old biases in service provision. Before peace, war was perceived as the central constraint to service delivery, which provided a convenient and all-embracing excuse for every sort of failure. More structural weaknesses, such as the urban and hospital biases, the inadequate management capacity, the poor training and support systems, the over-ambitious goals and the precarious financing basis, “hidden” by the war, were neglected or downplayed. The peace dividends were expected to be large. The NHS, perceived as fundamentally healthy, was expected to recover spontaneously with the return of peace. This is a common misconception in similar situations (Macrae et al., 1996), such as in Angola where the never-ending war seems to paralyse forward thinking and postpone forever discussions about reconstruction.

Peace and the transition phase: 1993–1995

Running health services after the peace agreement was far more difficult than had been anticipated. In 1993, after the signing of the agreement, as the system was unable to adapt quickly to the new transitional environment, operations slowed down and service output contracted. Rebuilding in devastated rural areas was slow and expensive. Health workers were reluctant to move out of the main towns, and as displaced populations returned home their access to the existing health facilities decreased. The costs of the transitional period and of peace-building (slowly becoming patent) were huge, largely offsetting the expected peace dividends. After this initial contraction, a sustained expansion in geographical coverage and service volume, which increased by 20 per cent in aggregated terms between 1994 and 1996, took place. Service consumption in peripheral rural areas increased threefold (Ministry of Health, 1998). The new government, installed after the 1994 general elections, endorsed the previously developed plans, providing policy continuity despite the changing political situation.

After the peace agreement, management tasks took over from planning ones. As officials were totally absorbed by the new pressing demands of reconstruction and service expansion, no manager had the time or energy to concentrate on planning issues. Thus, the plans finalized by 1992 were rather successfully implemented, whereas areas lacking a clear MoH policy were left open to many uncoordinated donor-led proposals. For instance, many initiatives, in turn promoted by UNICEF, USAID and the World Bank were launched in the management-reform area, without significant success. The policy dilemma faced by the MoH was, on the one hand to avoid any major disruption to the management system of the time, which had survived enormous stresses, thus proving itself sound. On the other hand, a profound and comprehensive reform of the health sector was imposed by the remarkable changes that were affecting the country.

Box 6 Health activities supported by UNHCR and the EU

Between 1993 and 1994, UNHCR financed 19 NGOs for the rehabilitation or construction of 92 health facilities in 36 districts; of those projects, 23 per cent targeted ex-RENAMO areas. Several of these health units remained closed, because provincial authorities had no funds and staff, nor supplies to make them operational (Colombo, 1995).

An analysis of the EU support to the health sector between 1992 and 1996 (Colombo, 1997) identified 57 projects, implemented by 33 NGOs and 1 UN agency, while 3 other projects were managed by the MoH, with external assistance provided by the funding agency. The study concluded that, based on a conservative estimate⁵¹, the EU sector contribution amounted in those years to around US\$80.5 million, 53 per cent of the total being channelled through NGOs. This was an enormous amount of money for the health sector, spent in a myriad of uncoordinated projects of questionable efficacy. Neither UNHCR nor the EU fully accepted the coordinating role of UNOHAC. Neither agency could rely on in-house technical capacity⁵²; they did not establish any close relationship with the MoH, nor with other better-equipped agencies. Their aloofness was therefore self-inflicted.

⁵¹ The estimate did not include funds directly managed by HQs, such as ECHO, nor co-financed projects.

⁵² UNHCR recruited a health coordinator (one of the authors of this report) only in 1995.

During these years of transition, service provision in RENAMO-controlled areas was high on the agenda of many donor agencies. The population confined there had been excluded from access to formal health services for many years. Despite mutual distrust and occasional incidents, both parties allowed NGOs to revive services in these areas. While the NGOs played an important political role in opening up RENAMO areas, the impact of their interventions on health-service provision was controversial, especially when the scale of the intervention is taken into account⁵³. Routine data, mainly related to health service outputs available at the time at the MoH, did not suggest better performance in areas supported by important projects when compared to areas without external support. There is even anecdotal evidence that NGO resources might have substituted local ones, which were moved to other zones or, worse, left idle. Whereas many projects carried out internal evaluations, no systematic external appraisal of their impact on the health system's performance was attempted.

Despite these shortcomings, the political significance of the indirect collaboration between hostile sides was remarkable. Often, health services were the first signs of the coming normalisation of civil life. A serious problem faced by the health sector was how to deal with health workers active in rebel areas (Box 7). The intense rehabilitation work going on in RENAMO areas resulted in the opening of many health facilities, whose functioning was precarious due to understaffing and inadequate supplies. RENAMO health authorities came progressively to accept health workers from the government side, first employed by NGOs and eventually by the MoH, as the sole option for staffing these new facilities. The whole process powerfully contributed to the progressive reintegration of rebel areas into a common administration.

Box 7 The reintegration of RENAMO health workers into the NHS

A survey of RENAMO health personnel, coordinated by UNOHAC, in consultation with the MoH and RENAMO, gathered information on approximately 500 health workers (Colombo, 1994a): 78 per cent had no formal training, while their average schooling was slightly above the fifth grade, making the majority of them ineligible for direct enrolment into the NHS. Thus, a comprehensive programme to retrain the majority of them to levels equivalent to those required by the NHS was launched. This defused a source of tension and demonstrated to suspicious rebels the MoH's willingness to proceed on the path to reconciliation.

Efforts to improve donor coordination started in 1990–92, and were quite successful at the central level (Pavignani and Durão, 1999), mainly due to the energetic action of the lead donor agency (Switzerland). New instruments aimed at rationalizing external assistance, such as sector budget support and pooling arrangements for technical assistance and drugs, were incrementally introduced. A conspicuous body of information on resource allocation and service outputs across the country was made available to agencies and NGOs, enabling a fruitful partnership with the MoH and thus reinforcing the Ministry's position. However, some key actors (e.g. the European Union, USAID, World Vision) were absent from the process, while other agencies formally accepted the coordination forum but resented the apparent loss of status and the (admittedly loose) control exerted by MoH and lead agency. The participation of these actors was mostly cosmetic: some agencies pursued their own agendas, launching unilateral initiatives, which undermined the coordination effort. Progress

⁵³ By mid-1994, at least 37 different agencies were operating in the health sector in former RENAMO areas across 51 districts (United Nations, 1995).

towards better coordination was less satisfactory at the provincial level, despite the many efforts in this direction.

The same recalcitrant stance towards coordination has marked certain agencies over the years, despite the evolution of the context and the strengthening of the coordination tools put in place. Even the patent success of some of these arrangements has been flatly ignored by agencies that positioned themselves above the crowd. The reconstruction policies, formulated by the MoH and since 1992 widely circulated among donor agencies, stimulated mixed reactions. Most bilaterals accepted or at least gave serious consideration to the policies proposed by the MoH. Conversely, most UN agencies plainly ignored them. Those agencies with a prescriptive strategy elaborated by headquarters and/or with a short mandate tended to see the GoM as an obstacle and to ignore it. More autonomous country offices, with a longer history in Mozambique and a better grasp of the local picture, tended to be more sympathetic towards MoH efforts to sketch an appropriate, realistic and locally owned policy (Pavignani and Durão, 1999). Whereas the discourse prevalent in the donor community is one of increasing commitment to coordination, major changes in the aid relationship and a radical reshaping of the culture of certain agencies will be required to achieve progress in this area.

The health sector was characterized by fragmented, donor-assisted projects, usually covering investment, technical assistance and equipment. Recurrent costs were financed through parallel and inefficient procedures⁵⁴. To most donors the political situation in the early 1990s did not seem a promising base from which to experiment with more institutionalised models of assistance. Contrary to the general wisdom, SDC decided to support recurrent expenditures, providing budget support to save the NHS from collapse and to boost the delivery of health services through the injection of resources to meagre provincial budgets. There are indirect but consistent indications of the contribution of budget support to the expansion of service volume. Moreover, budget support has powerfully contributed to the strengthening of the information system, in this way allowing the monitoring of reconstruction trends, as shown in Box 8 (Colombo et al., 2000).

Box 8 Mozambique NHS trends, 1993–1998

According to routine reporting, the NHS total output expanded significantly during the mid-1990s.

	Trend 1993–98
Inpatient days	+12%
Outpatient contacts	+75%
Deliveries	+39%
Mother & child care contacts	+82%
Immunisations	+184%
Service units	+42%

Note: 'Service units' is used as a broad estimate of service output and is computed as the following weighted sum: $\sum(\text{inpatient days} \times 9) + (\text{hospital deliveries} \times 12) + (\text{vaccination doses} \times 0.5) + (\text{outpatient consultations} \times 1) + (\text{MCH consultations} \times 1)$.

⁵⁴ According to then Vice-Minister of Health, no more than 20 per cent of funds for recurrent expenditure of these projects entered the system.

Most of the reported growth took place in rural areas. Whereas health services in big cities grew by only 12 per cent, the rest of the health system expanded by 78 per cent. Consequently, in 1998 big cities accounted for 42 per cent of the total output, down from 54 per cent in 1993. Large hospitals reduced their contribution to total service volumes, from 33 per cent in 1993 to 22 per cent in 1998. Rural districts expanded their share from 30 per cent in 1993 to 39 per cent in 1998. Growth was more significant in the least favoured areas (such as the Northern provinces and Zambézia).

Region	Growth 1993–1998
Northern and Zambézia	+57%
Central	+36%
Southern	+45%
Maputo City	+16%

After 1995, the fragmentation of external assistance decreased, as many relief-oriented agencies and NGOs scaled down and eventually closed their operations. The remaining organizations redirected their approach to the new context of development.

- The visibility of multilateral agencies declined and bilaterals became more influential in policy-making and resource allocation. Important agencies subscribed to the MoH reconstruction strategy, carving out a role for them, within the global effort.
- Information flows were strengthened and streamlined, enabling more accurate decisions, in agreement with the plans previously developed. Policy dialogue between donors and the MoH gained strength, openness and visibility (Pavignani and Durão, 1999).
- The MoH strengthened its technical capacity. Modern office equipment became common, and working standards were raised. Bodies of acknowledged expertise, such as GACOPI (the MoH body in charge of coordinating investment projects) affirmed themselves.
- More qualified staff were contracted; incentives, mainly provided by donors, became available to many cadres, improving their morale and in some cases their efficiency. A large number of national cadres benefited from training abroad.

Normalisation: 1996–2000

The plans formulated by the MoH in 1991-92 addressed human resource development and global investment, but neglected several other important areas, such as management reform (including decentralization), local reconstruction plans, drug policy, financing reform and quality of care. There was a delay of several years before these matters were adequately considered. Although the MoH was aware of the critical importance of these issues as early as 1992, several reasons led to a delay in tackling them:

- pressing, competing managerial tasks of keeping the NHS running in a very difficult period;
- the unstable environment of the time, which made many decision-makers reluctant to embark on detailed plans and long-term initiatives;
- scarcity of skilled specialists, able to translate policy statements into operational plans;
- the objective difficulty of developing strong policies on sensitive issues.

It is probably fair to state that, at the time, the MoH made the best use of its over-stretched policy formulation and planning capacity, but that this fell short of the demands imposed by a complex, sensitive and unstable situation.

One of the most problematic issues was the charging of user fees. A charging system had been in place for many years, with revenues resulting in minimal contributions to the financing of the health sector – below 1 per cent in 1993 (Ministry of Health, 1998). The MoH, concerned about the capacity of the population to afford higher fees, and worried by the political implications of substantial increases in charges, refrained from increasing fees to significant levels. Cooperating agencies periodically raised the issue but did not push for a more resolute approach. Meanwhile, the steady reduction in health workers' earnings stimulated the progressive diffusion of under-the-table charging. Cost sharing has become mandatory, in order for the NHS to expand further⁵⁵ and for the present donor dependence to be reduced. In 1997, about half of the recurrent expenditure was covered by external funds; including investment, the external share exceeded 70 per cent (Ministry of Health, 1998), an unsustainable level. Even in the best scenario, cost-recovery will contribute to a minimal share of expenditure. Hence, internal financing, which has been growing steadily since 1997, will have to compensate for the likely decline of aid if a service contraction is to be avoided. The MoH capacity to attract additional external funds in the form of budget support for recurrent expenditure is also critical in improving equity in the allocation of resources and the efficiency of their utilization.

The NHS workforce has been restructured according to the plan formulated in 1992. Progress in this area has been substantial, and if the present pace is maintained the workforce could match the quantitative targets set by the plan for 2002. Ancillary staff are being reduced, and professional cadres are being upgraded. This has been the result of a major expansion of the resources allocated to training. Recurrent expenditure for training, financed by a number of donors who have endorsed the MoH's plan and actively collaborated in its implementation, has expanded dramatically. This impressive improvement might nonetheless be undermined by serious drawbacks related to the quality of the provided training, which is widely criticized, and to the long-term sustainability of the MoH's training system. In fact, in the short or middle term the state budget is unlikely to replace aid as the main funding of the training network (Vio, 1998). Meanwhile, a massive redeployment of personnel has taken place within the country. Rural facilities are better staffed, urban overcrowding has been controlled, and the internal gap between provinces has decreased (Ministry of Health, 1998). This massive restructuring of the workforce has been instrumental in fuelling the NHS expansion summarized in Box 8 above.

Concluding Remarks

Summing up, adaptive changes against a backdrop of continuity have been the prominent feature of the Mozambican health sector. The adopted policies, both those stated in official documents and those informally pursued by decision-makers, have evolved significantly. In fact, the national context of continuous change has provided a powerful stimulus to MoH and donor officials to reconsider prevalent thinking and adapt it to new pressing problems. The resulting picture is that of a health sector which, despite many misadventures and detours, proceeded overall towards agreed goals. In a context of extreme fragmentation and great autonomy of most actors, policies both relevant and realistic have been the crucial factor keeping reconstruction consistent and providing a global sense of direction. Despite the many weaknesses highlighted by this review, the strengths of the health sector during decades of turmoil stand out clearly⁵⁶. To survive economic crisis, war and natural disasters and to

⁵⁵ The present coverage is estimated at about 50 per cent of the population.

⁵⁶ A more detailed sector analysis can be found in Ministry of Health (1998).

recover after war, expanding health service delivery to serve rural and underprivileged areas of the country, are impressive achievements indeed. The popularity that the MoH has managed to nurture among donors, who have supported it through turbulent times, is understandable. As Mozambique recovers from crisis, and national authorities increase their control over the health sector, they have to ensure continuity with this brilliant legacy and live up to the insidious challenges of the present.

A cautionary word. The terms of our comparison have projected Mozambique under a disproportionately favourable light. However, worrisome signs that the reconstruction momentum has faded away are emerging. The MoH has stopped in its progression, not fulfilling the expectations (in terms of improvements in efficiency and transparency), which its past performance and the normalisation of the country have induced among NHS users and its external financiers. Political stability and insecure leadership have led the MoH to resist change. Policy formulation, decentralization, internal restructuring and effective integration of its vertical programmes are mainly discussed without registering much conceptual progress, nor being consistently implemented. The possibility that the Mozambican health sector, despite its past successes, falls prey to the same illness, which ruined its Angolan equivalent (vague policies, lack of leadership, postponement of painful decisions, neglect of information, laissez-faire), cannot be ruled out.

8 A framework: health-related dimensions of peace processes

“All receipt of information is necessarily the receipt of news of difference”
Gregory Bateson

In contrast to previous chapters which have focused on general and health-related features of Angola and Mozambique respectively, this chapter takes an overtly comparative approach, highlighting several dimensions in which contrasting patterns may help to further our understanding of complex situations. These dimensions are listed here, and then discussed in detail in relation to both countries.

The health-related dimensions distinguished are:

- historical;
- political;
- economic;
- war economy;
- military;
- ethnic;
- symbolic;
- psychological;
- magical;
- reconciliation;
- sociocultural;
- reputation and role of health authorities;
- PHC policies and service outputs;
- pharmaceutical policies;
- opportunities offered by a humanitarian environment;
- institutional settings of the humanitarian coordination body;
- scope of peace-building;
- documentation, memory and knowledge.

Historical

Mozambique had a “window” of peace soon after independence, when the ruling party enjoyed undisputed authority. This allowed the government (including the MoH) to formulate its policies. In fact, the post-independence Mozambican health policy was considered an Alma-Ata-inspired model of the most progressive options of the time (Walt and Cliff, 1986). These choices attracted a host of Western advisers and supporters, mainly volunteers recruited in the leftist and anti-apartheid camp, who facilitated the participation of national cadres in international debates and wholeheartedly contributed to policy discussion and ensuing implementation.

At independence, Angola was immediately engulfed in war. The country received a different type of technical assistance from socialist countries, who were less familiar with and less supportive of PHC policies. The MoH considered the same policy options as Mozambique, formally endorsed most of them, but did not resolutely implement any. The war conveniently justified this limited commitment, providing space to urban elites more concerned with high-

tech tertiary care.

Political

In Mozambique, the strong perception of health service delivery as a political statement was ingrained in the socialist ideology of the first years after independence, and was reinforced by the international praise earned for those early successes. This made health services a prominent political target for destruction by RENAMO, a military organization without substantive political goals, which had been conceived by the apartheid military as a device to destabilise the state, rather than to replace its rulers. Lacking technical people to design sector policies, RENAMO tried to formulate a rudimentary political programme only towards the end of the war, heavily relying on outside advisers clearly unfamiliar with the country. Therefore, it did not show interest in establishing parallel administrations, formulating sector policies and delivering services in its mainly depopulated areas from which the state had been forced to retreat. Even today, RENAMO's approach to health issues is at best cursory. After the Peace Agreement, the government showed to be confident on a smooth transition to the multiparty system. This attitude was reinforced by the outcome of the first elections: without needing to share power with the opponent party the government could reaffirm its legitimacy and its directive role in rehabilitation.

In Angola the government has shown a decreasing interest in social sectors. Due to the collapse of the state, its absence from large parts of the territory and the resulting governance void, the delivery of services by the end of the 1980s in rural areas and in some secondary cities was abandoned to NGOs (Duffield, 1994a; Christoplos, 1998). UNITA, born from a nationalist movement, with an embryo political programme and large populations under its control, is said to have paid more attention to administration and to service delivery. However, as discussed above, some considered that UNITA's concerns with health-care delivery were merely propaganda tools for outside consumption. Whereas its army health services were regarded as fairly sophisticated, those offered to ordinary civilians were reportedly rudimentary and under-resourced.

Economic

Mozambique, poor in natural resources, had to struggle to survive and has been heavily dependent on aid and on regional relationships for its service economy. Thus, donor leverage has been strong and influential on the peace process. In fact, robust financial incentives have been provided by third parties (including donor governments and private corporations) to the warring sides, particularly RENAMO, increasing in this way the returns of a peace deal (Vines, 1998b). The sustained external support that the sector received in wartime must be seen in this perspective.

Angola, confident of oil and diamond revenues, has been less active in mobilizing external resources. This optimism partially explains the over-ambitious initiatives in urban high-tech tertiary care. The health sector has never been able to secure the staunch support of external partners, who have remained sceptical about the content of stated policies and doubtful of the MoH commitment and capacity to implement them.

War economy

In Mozambique, the RENAMO strategy based on the violent exploitation of forced labour for the subsistence of its army, can be classified as a "predatory war economy" (Le Billon, 2000). This strategy proved to be short-sighted and vulnerable to shocks: with the withdrawal of external support, the drought in Southern Africa in the early 1990s and the exhaustion of

already scarce food resources accelerated the movement's decline. Additionally, it eventually alienated the political support it had previously enjoyed. The impact of this strategy was considerable on all aspects of the livelihood of the people, including those not under direct military control. The 1997 census showed vividly the human cost of a fully-fledged predatory war, with a total population of about 2 million fewer than indicated by projections based on 1980 data. Although a sizeable share of the missing population can be accounted for by refugees remaining abroad, this figure remains staggering.

Two categories from the framework proposed by Le Billon (2000) well describe the Angolan case: a "commercial war economy" superimposed on the "predatory" variety. The war has resulted in enclave economies for the exploitation of strategic local resources, at the expense of the development of other sectors. The emergence of a merchant class, allied to the political and military elites of both parties, has been favoured by strong economic links with powerful external players. The control of strategic, resource-rich areas, rather than of populations, becomes the primary goal of the belligerents. The impact of the severe and protracted violence on the population cannot be quantified, but it is certainly huge. Additionally, the cost of the war, in terms of lost opportunities for development and degradation of the social fabric, cannot be overemphasized.

Military

Towards the end of the war in Mozambique, due to the huge humanitarian crisis caused by the drought, cross-front health activities carried out by NGOs contributed to decreasing tensions and ultimately to dismantling military control on people movements (despite RENAMO's initial desire to maintain its local control). Further, the highly visible health activities in accommodation camps for displaced persons attracted people from RENAMO-controlled areas. Investment in health since independence stimulated the emergence of a peace-oriented elite, quite influential within the government. The high profile enjoyed by health in the government may have played a role in reassuring donors about its aims and capacity⁵⁷. Thus, an alliance crossing the government-donors divide has ensured that substantive resources were allocated to the health sector.

In Angola, cross-front health activities were less evident and less influential, because of UNITA's iron grip on circulation of outsiders and the much heavier mine density. The Angolan army absorbed a large number of cadres and invested in their training, depleting other sectors of talented young people. This has taken a heavy toll on the health sector. For instance, 50 per cent of the medical doctors who graduated in 1991 were absorbed by the army (Feret and Gardete, 1992). While a dominant military elite may not necessarily be prone to waging war, it will necessarily have an objective interest in it and a certain propensity to perceive military solutions as the most appropriate.

Ethnic

Whereas the roots of the Mozambican civil war have to be sought in apartheid aggression, in FRELIMO's failure to rule over a functioning economy and in its authoritarian instincts, RENAMO's ascendance introduced a strong ethnic connotation to the political debate. In the health sector, the dominance of Southern cadres, although due to the traditional educational advantage enjoyed by the South in relation to the rest of the country, was deeply resented by people in Northern and Central regions. Despite the widespread malaise, which is becoming

⁵⁷ The incumbent president was a medical student. The Prime Minister and the Minister of Foreign Affairs are both medical doctors and former Ministers of Health.

dramatically manifest today, health-care provision has not been seriously affected by ethnic concerns. The imbalances in service provision, which existed in wartime, still persist today, despite substantial improvements. However, these are easily explained by the investment choices of the colonial era, in terms of both physical assets and human capital, which still condition the sector. To counter this situation, donors and government agreed to bias rehabilitation interventions towards less privileged regions (such as Zambézia province), hence countering the ethnic argument of discrimination against these areas. A solid factual argument of effective historical neglect, stemming from the colonial past, was put forward to support this gesture, which became therefore less contentious. The preference given to neglected parts of the country was therefore construed as fair redistribution of available resources, operated by an unbiased government, rather than an attempt to soothe political grievances. The explosiveness of these issues was however underestimated by the government, which has met rising hostility in the very areas most benefiting from reconstruction. Admittedly well-intentioned policies need not only good technical implementation, but also good marketing to political constituencies.

In Angola, the polarisation of the political discourse across the ethnic divide is reinforced by the disproportionate share of resources allocated to Luanda (often on arguable security grounds) in relation to the rest of the country. This has contributed to strengthening the economic and cultural gaps separating the capital from the country, in this way fuelling ethnic grievances. Health care provision follows the general pattern, and there are no signs of improvement. Beyond allocative distortions, there is no report of deliberate bias in health care delivery based on ethnic consideration. The overlap between ethnic, rural/urban and party allegiances makes it difficult to draw conclusions about discriminative patterns, real or perceived.

Symbolic

In Mozambique, destitute villagers saw the delivery of health services in areas previously inaccessible and/or insecure after years of war as a sign of normalisation of life. Renewed health services, no longer attracting guerrilla attacks, were eagerly sought by everybody, political affiliation notwithstanding.

In Angola, the absence of visible and substantial investment in revamping services in war-battered areas confirmed the lack of confidence (and perhaps interest) felt by all parties in the peace process. Services always took second place to military concerns during the troubled reintegration of UNITA areas under state administration.

Psychological

Even at the peak of the national crisis, Mozambicans perceived their tragedy as a one-off, if protracted, event. Hopes of resuming normal life never faded completely, and a general war-weariness was, perhaps, the most important driving force towards a steady reconciliation. This may explain the MoH commitment to develop quite elaborate reconstruction plans, which proved valuable in controlling the chaos of the transitional period.

In Angola, hope has been so blatantly betrayed by the events following the 1992 elections, that the prevalent posture is one of detached cynicism. Clearly, after so many disappointments, the emotional price to be paid if another chance of peace is squandered is too high to be borne by most Angolans. This prevalent feeling plays a role in reducing the interest of most officials in discussing how the postwar health sector could be. Past attempts in this direction, such as the Pre-Investment Study financed by the African Development

Bank in 1992, carried out by outsiders, written in French and quickly sidelined, have been at best half-hearted. Reticence notwithstanding, given the massive endeavour required for reconstruction, to embark upon it without a considered strategy would be a recipe for disaster. The plans recently sketched by the Angolan MoH (see Chapter 6) deserve staunch support to enable them to reach fruition.

Magical

According to available sources, magic and supernatural powers have played a very important role in Mozambique. RENAMO, true to its nature as a traditional war organization, relied heavily on magical practices. Samantanje (Vines, 1991) and Mungoi (Maier, 1998), two spirit mediums, the former operating near the RENAMO headquarters, the latter in southern Mozambique, acquired country-wide fame. While Samantanje reportedly purveyed magic to both parties, Mungoi successfully offered protection to a village in a government-controlled area, which remained unscathed for most of the war, whereas the surrounding settlements suffered heavily from RENAMO attacks. Another spirit medium, Manuel Antonio, had a profound impact on the course of the war in the crucial central front, by creating a voluntary army, the *Naparama*⁵⁸. These fighters, using “white weapons” and protected by magic charms, in 1990 managed to score repeated military victories over RENAMO and free a significant portion of Zambézia province within a few months.

While the influence of powerful spirit mediums over politics and other societal spheres is a widespread phenomenon in Africa, and the emergence of traditional armies is not infrequent (Behrend, 1999), similar occurrences have not been reported in Angola, with the conspicuous exception of Jonas Savimbi himself, who was widely believed to rely on magical practices to assert control over his followers (Minter, 1994). The massive urbanisation of the Angolan population, combined with the disruption of communities and the ensuing uprooting from traditional life, can be advanced as possible reasons.

Reconciliation

In Mozambique, several developments inside and outside the health sector showed commitment to the peace process. Examples include: the reintegration of RENAMO health workers into the NHS, which played a role in demonstrating government commitment to overcoming hostilities; the government’s acceptance of relief activities in RENAMO areas before their integration into a unique state administration; and the joint planning of the health component of demobilisation. Furthermore, the whole peace process was marked by a vast array of rituals, well rooted in traditional practice, intended to mark a departure from the painful past (Honwana, 1998). These widespread practices were immensely influential in setting the whole population on a path to peace-building, particularly at grassroots level. The incorporation of former enemies into common organizations (whether the army or the health sector) was smoother than expected. This outstanding capacity of Mozambicans to forget the painful past and move beyond it (well consolidated in a country prone to traumatic events) seems unique.

In Angola, the picture could be very different, at least looking at the robustness of the rivalry between Ovimbundu and Mbundu, embodied in UNITA and MPLA respectively (Cahen, 1997; Green, 1999; Chabal, 2000). Several respondents are not aware of equivalent ritual practices aimed at reconciling foes. Given their existence in Angolan culture, as confirmed by

⁵⁸ “Irresistible force” in the local language.

several informants, the abstention from embarking on these practices on a wide scale suggests a prevalent disbelief in the peace process. Joint initiatives to promote reconciliation, brokered by donor agencies and NGOs, had little impact, given the general diffidence and the predominance of political/military considerations. Success stories at local level failed to capture the attention of national decision-makers on both sides.

Sociocultural

Mozambique is culturally and geographically open to and dependent on the outside world. Having a tradition of dealing with different foreign influences, Mozambicans interacted actively with, and took advantage of, foreigners involved in the peace process.

The Angolans, more diffident (with good reason, given the heavy enmeshing of foreign powers in their conflict) have kept outsiders at arm's length. Arguably, interactions between nationals and expatriates remain problematic. Only a few foreigners settle in Angola for long periods and reach a satisfactory level of understanding of the language, habits, beliefs and intricacies of the country. As a result, donor agencies and international NGOs are more prone to making mistakes, thus reinforcing Angolan diffidence towards foreigners.

Reputation and role of health authorities

In Mozambique, continuity with a past perceived as successful, consistency of policies and some technical capacity at the top level gave credibility to the MoH, which was accepted as a serious partner by many players in the peace process and won allies among donors and NGOs. Although fragmented, the health sector maintained a sense of direction during the transitional years. Coordination of external assistance (general and sector) had a long tradition of innovation and success in Mozambique (e.g. UNSCERO for emergency relief, the Swiss Development Cooperation for the health sector). The most important feature in this field has been open, action-oriented dialogue between partners (Pavignani and Durão, 1999).

In Angola, the problems of rapid turnover of MoH officials, vague policies not consistently implemented and difficult dialogue with partners have undermined the MoH standing. Without leadership, the main actors proceeded uncoordinated, unaware of each other. To identify the direction taken by the sector has been utterly difficult. Without the MoH in the lead, coordination efforts never materialised into concrete joint action at central level. Some tentative attempts at coordination at provincial level registered limited success, without being consolidated into a comprehensive national approach.

PHC policies and service outputs

Mozambique invested heavily in the training of PHC-oriented cadres, who by now represent about half of the skilled workforce. Their professional profiles were consistently field-tested and accordingly updated over time. These cadres, with job descriptions making them ineligible for deployment in hospital, maintained a comparatively stronger presence in peripheral areas even at the peak of the war (Ministry of Health, 1992). During the 1990s, substantive resources were allocated to training facilities designed to provide appropriate PHC-oriented models. These choices have been contentious, as they were made against the powerful medical lobby, the magnetic attraction of large hospitals and main cities, and entrenched practice. Only firm political will, backed by evidence of the success, enabled the health sector to persist in this policy.

In Angola, the preponderant medical, hospital-oriented model discouraged investment in appropriate cadres and led to neglect of time-honoured professionals such as midwives. In the

years after independence, PHC-oriented training was actively opposed (Chabot, personal communication). Concomitantly, Mozambique has shown vastly higher patterns of health care consumption than has Angola. The customary explanation for this gap, that the war has discouraged health service development, is at best inadequate. Unfortunately, it is not possible to compare reported coverages, because of the millions of Mozambican refugees abroad who are usually included in the figures.

It is possible to compare service uptake in urban, relatively secure and privileged areas. Indeed, the vast urban population of Angola should be an easy target for resolutely promoted health services. During the war, this has been the case in Maputo City, which achieved very high coverages and maintained them over time, at very low opportunity cost, given the overcrowding of people, health workers and equipment. Table 7 compares coverages achieved by the two capitals in different years. Without arguing that the higher service uptake in Mozambique is the direct result of the country's PHC choices, it seems sensible to conjecture a relationship between the two factors.

Table 7 Selected service coverages in Luanda and Maputo

Service	Luanda (1997)	Maputo (1992)
Delivery coverage (%)	36	66
Fully immunised children (%)	35	85
Outpatient contacts per head (number)	0.46	1.31

Sources

Angola: INE and UNICEF, 1998; Ministério da Saúde, 1998c.

Mozambique: Ministério da Saúde, 1993.

Pharmaceutical policies

In Mozambique, a progressive drug policy was conceived and aggressively implemented soon after independence, by a MoH confident in its capacity to take on pharmaceutical firms and their local clients, including the medical lobby. A ruthless rational selection reduced the number of drugs to be imported to about 300. Competitive bidding, purchasing in bulk and generic prescription according to vigorously promoted standard therapeutic guidelines achieved dramatic efficiency gains and earned international praise (Barker, 1983). Despite the recurrent financing crises, absolute under-financing, frequent shortages and an unfavourable environment, the NHS has remained fairly well supplied with drugs over the years (which largely explains the higher service uptake discussed above), thanks to a rational approach to an area affected by well-known market failures. This may explain why donors, including even those most sympathetic to privatisation, have been keen to fund drug purchasing through public channels. As late as 1997, a World Bank report confirmed the overall soundness of the system in place (Folkedal and Kostermans). Aware of the changed, market-oriented context, the MoH is wisely reforming this successful subsector, with the explicit goal of preserving its efficiency and effectiveness (*Ministério da Saúde, 1995*).

In Angola, a less confident MoH has not been able to restructure the pharmaceutical area, which has remained fragmented and appallingly inefficient. Drug scarcity has become a distinctive pattern of the Angolan health sector, despite funding levels similar to or even higher than those in Mozambique. The better financing position of the Angolan Treasury may have played a role in postponing controversial measures, such as the closing down of private

drug importers. A weaker grip on the economy by the government may partially explain this restraint. Again, a large and predominantly urban elite has probably contributed to making the MoH leadership shy of introducing reforms.

Opportunities offered by a transitional environment

War may have different effects on a health sector. Vast material destruction and the collapse of existing systems may induce a radical rethinking of the previous situation and the reshaping of the sector. Conversely, war can hide weaknesses and provide a comfortable excuse for postponing painful decisions. In wartime, the health sectors of Angola and Mozambique came to face similar challenges – fragmentation, dependence, limited control over events – but reacted differently. Whereas initiative, risk-taking, investment in information and forward planning prevailed in Mozambique, passivity, neglect of information and the wholehearted adoption of vertical approaches undermined the capacity of the Angolan health sector to adapt to the new situation. *Laissez faire*, when adopted, has shown its shortcomings in Mozambique too, for instance in relation to cost-recovery.

In Mozambique, the opportunity offered by reconstruction of building a modern, equitable and sustainable health sector was seized with qualified success. The exercise, although incomplete, brought dramatic improvements in terms of accessibility, equity (see Box 8 above), appropriateness and long-term sustainability of the health sector. In Angola, scepticism about the end of the war has undermined the debate about reconstruction. The few interesting attempts in this direction (such as in human resources) need further development and full political backing to be borne to fruition.

Institutional settings of the humanitarian coordination body

In Mozambique, UNOHAC, the UN humanitarian arm during the transition period, was included within the global peacekeeping operation, ONUMOZ. This arrangement limited UNOHAC's autonomy, but put the humanitarian component firmly in the political/military agenda. This potentially contentious institutional setting proved overall to be effective within a successful peacekeeping framework. UNOHAC was only partially and indirectly involved in the humanitarian aspects of the demobilisation process during the cantonment phase.

In Angola, UCAH, the humanitarian body, was intentionally kept separate from the other components of the UN peacekeeping operation, UNAVEM, which was criticized for the post-Bicesse failure and was considered too exposed to political blackmail. In the sensitive Angolan environment, this setting, giving UCAH a large area for manoeuvre and making it "neutral", was a reasonable choice, which protected humanitarian action from UNAVEM's political risks. UCAH was fully and directly involved in the humanitarian aspects of demobilisation. Agencies and NGOs (including UCAH) could rely on the direct transfer of expertise in peacekeeping operations, as many relief professionals who had previously worked for ONUMOZ in Mozambique, and gained precious experience, then moved to Angola.

Scope of the peace process

In Mozambique the peace process encompassed most dimensions, including the social, political and economic, hence the relatively high profile enjoyed by health. Overall, as the expansion of health services prioritized neglected or previously inaccessible areas, people were exposed first to the state as service provider, receiving a tangible "peace dividend". Civil administration, police, army and taxes reached remote districts well after health services, schools and boreholes. Although these latter services were mainly provided by

NGOs and financed by donors during the transitional period, the government participation in the process was sufficiently visible to earn it at least partial credit.

The scope of the peace process was narrower in Angola, as it focused on military and political control, little or no attention being paid by the government to social services in rural areas⁵⁹. The distance separating government authorities and NGOs precluded the former from being identified with the benefits provided by the latter. Thus, people were confronted first with the state as controller, rather than as the provider of valued services.

Documentation, memory and knowledge

These assets are quite developed in Mozambique, in terms of both written materials and expert personal memories. The Mozambican willingness to revisit past choices and adjust approaches to new contexts (see Box 9) contrasts sharply with the aggressive stance of the Angolan government, constantly hoping to win a decisive military victory, and feeling uneasy with criticism of the choices it has made.

Box 9 Revisiting the past

At the height of the war, FRELIMO commissioned a researcher to study the roots of the war in northern Mozambique. The study turned out to be an explosive critique of the government's agrarian "villagization" policies, which according to the author caused profound political discontent and favoured the growth of RENAMO (Geffray, 1990). Despite its objective methodological flaws (eagerly stressed by its numerous critics), the study marked a milestone in the understanding of the war and opened the way to a flurry of serious and unbiased research, which is slowly reconstructing a troubled but crucial historical period.

That a battered government, waging an inconclusive but ruthless war and seemingly on the verge of military defeat, had felt sufficiently confident to commission such a study and circulate its findings freely is nonetheless remarkable. The quiet but radical rethinking of policy conducted by FRELIMO towards the end of the 1980s (Newitt, 1995), seems in retrospect to be a high-level equivalent of the healing rituals which proliferated in the field. As the latter were instrumental in reintegrating traumatised people into their communities, the former has contributed to devolving a measure of legitimacy to rule to a party in serious crisis.

The overall stability of MoH managers enabled the retention of some organizational memory. Furthermore, documentation and analysis of events taking place in the health sector continued and flourished over the years. During the last years of emergency in Mozambique, functions of intelligence were carried out by a group of UN officials collaborating with UNSCERO, which used information from various sources including the health sector to estimate population sizes, needs and movements, and to guide relief operations. Later, as confidence in the peace process was increasing, an informal network of analysts consolidated in the health sector, documenting the events of the previous years. Some crucial findings of

⁵⁹ One respondent, who participated in the Lusaka negotiations, could not recall a single occurrence of discussion related to health services.

this work were retained by most stakeholders as reliable and relevant to decision-making⁶⁰.

Information and documentation are particularly weak in Angola, as most actors (national and expatriate) have left the stage and little has been written down. Available analyses are weakened by an extremely deficient information base, which makes authors reluctant to draw conclusions. The sequential review of available documents makes sorry reading, marked as they are by an almost ritualistic description of big structural problems left untouched and growing over the years. Large gaps and conspicuous inconsistencies undermine virtually every dataset, and long-term trends are hard to discern. Important documents and data are no longer available. Even successful initiatives are not documented, their findings are not disseminated, and given the rapid turnover of most officials, they are quickly forgotten.

This information gap is caused by several factors. The intensity and duration of the war, by preventing access to information on the ground, and by imposing a high turnover of professionals, due to security and hardship factors, have curbed research and documentation efforts. The continuous disruptions suffered by the health system, coupled with the general lack of confidence in a favourable outcome of the conflict, has discouraged and made impossible the consolidation of reliable information over time. Additionally, much more effective control has been exerted by the security apparatus in Angola over journalists, researchers and professionals. Lastly, since the aid system has been not dominant in Angola, as it has in Mozambique, its associated research has been less robust.

⁶⁰ Unfortunately, the major beneficiary of this intelligence work (the MoH) failed to recognize its usefulness (or felt threatened by some conclusions of the analysis, which threw light on a number of conspicuous MoH failures). The network was not consolidated and gradually disbanded.

9 Discussion

“Without memory, we are nothing”
Luis Buñuel

From the analysis presented in the previous chapters, several lessons, mainly drawn from the Mozambican experience, can be retained. They apply quite comfortably to Angola and possibly to other troubled countries emerging from conflict. This learning is presented here in the following 14 points.

1 The “back to past” fallacy

The goal of “returning to the pre-war situation” has shown to be flawed. Protracted conflict transforms all the aspects of the society, including those that have contributed to its deflagration. In Mozambique, the past success of the health sector, despite its patent drawbacks and its linkage to an extraordinary historical context, was idealised, not recognizing the pervasive changes to have affected the society, the public and the workforce. Only a sincere and robust reassessment of the past has enabled the MoH and collaborating donors to make forward-looking choices. In Angola, fuelled by over optimistic estimates of the internal financing capacity, the temptation to indulge in the same back-to-past fallacy, once reconstruction eventually starts, might be strong.

2 Restructuring the health network

Reconstruction after extensive destruction represents, therefore, a unique chance to build a balanced and equitable NHS, as it offers the opportunity to reconsider the whole system and plan it on a comprehensive, rational basis. Substantial resources may be available for investments addressing major allocative distortions. While the atmosphere of change may reduce resistance to altering the status quo, to abandon unwanted facilities is made easier by massive destruction and dilapidation. The urban and hospital biases, everywhere intractable in peacetime, can be tackled more successfully in post-conflict situations, taking advantage of the derelict conditions of most hospitals. Thus, building an equitable and sustainable health system may become a realistic target. A country emerging from a prolonged crisis cannot afford to miss that chance. As allocative decisions related to recurrent expenditure are heavily influenced by investment choices made decades ago, investment decisions made today will shape the health sector far into the future. Therefore, they should not be taken lightly, in the enthusiastic, optimistic mood that can accompany reconstruction.

3 Planning before peace

To reduce the unavoidable chaos and delays that characterize transitional situations, comprehensive planning *before* peace is critical. Plans should be built on a solid information base, with realistic and flexible timetables, in order to accommodate the demands of participating partners, and the many events unforeseen at the time of their formulation. Admittedly, plans formulated before peace incur the risk of being made obsolete by major events, such as a recrudescence of military activities (the Angolan events providing an eloquent example of this risk). Disturbing as the perspective of abandoning thoroughly prepared plans can be, this has to be weighed against the risk of entering into a transitional phase without a well-conceived strategy.

Situation analysis and documentation are, therefore, priority activities, even if, in the frantic climate of transitional periods, managers are usually too busy with daily operations to pay

adequate attention to data collection and analysis⁶¹. Thus, unique opportunities to follow and understand crucial processes are missed, and major mistakes can result. Despite the importance of information, caution is needed, as in unstable situations information becomes quickly outdated and therefore useless to hard-pressed decision-makers. The kind of data collection and analysis required in these contexts is necessarily “quick and dirty”. When related to the concrete dilemmas faced by involved actors, this information can prove invaluable.

4 Acknowledging the difficulty of reconstruction

Reconstruction is more difficult than expected during the war period, charged as it is by political considerations and expectations. In the new context, none of the war-related excuses for failure is allowed. Uncoordinated donor investments can target politically sensitive areas, such as rebel-controlled zones and where refugees are returning, creating serious distortions in an already biased health network, and exceeding sector absorption capacity. In Mozambique, rehabilitation was charged with sensitivities: for the government, it was a political statement of legitimacy and continuity; for RENAMO, a way of gaining recognition as administrator of unserved areas; for donor agencies and NGOs, the most visible strategy to justify their presence in contested areas. Thus, all parties were pushing ahead with civil works. No detailed plans, consistent with the national overall strategy, were developed at provincial level, leaving room for improvisation and amateurism. Rehabilitation standards were often poor. Funds to cover start-up costs of newly constructed facilities were seldom allocated by donors. Those areas with better security or easier access were over-resourced, thus introducing unsustainable patterns of service delivery still patent today. The development of the virtually non-existing indigenous private building sector was largely fuelled by donor largesse, through uncountable failures. In Angola today, the difficulties of rebuilding a derelict health sector seem to be vastly underestimated.

5 Rehabilitation and reconciliation

Rehabilitation and reconciliation go together and reinforce each other, but confront governments and aid agencies with difficult choices and compromises. In the aftermath of a peace agreement, the political outcome is usually unpredictable. Many crucial aspects are difficult to forecast: speed of return of refugees and IDPs to their home areas, resettlement patterns, disarmament and so on. At the same time, expectations of restoring normal livelihood are high. Immediate investment in reconstruction presents high political risks, but waiting for the consolidation of the peace process can be even riskier and undermine the reconciliation efforts. It has been observed that rapid and tangible benefits are required to foster reconciliation and to re-legitimate the state (Green, 2000). However, rapid, visible and short-term projects, such as the QIPs, if implemented outside a realistic and balanced reconstruction framework, can be inappropriate as first priorities and result in the wastage of precious resources, failing to contribute effectively to reconciliation.

In Mozambique, many refugees, IDPs and ex-combatants went back home without waiting for the local school or health centre to be rehabilitated. The rush of aid agencies to implement community projects often resulted in health centres that never opened because of the lack of start-up funds, equipment or staff, or in schools without teachers and/or books. It cannot be argued that expectations were low because of the pre-existing low coverage of health services: refugees and IDPs were often used to good-quality health care provided by NGOs in

⁶¹ “The first casualty of complex emergency is numbers” (Apthorpe, 1998).

accommodation camps, or enjoyed easy access to health services when living in urban areas.

6 Coordination of external support

When the reconstruction process is highly dependent on donor resources, and the donor community is large and composite, as it was in Mozambique, aid management and coordination of donor interventions are crucial to attenuate the fragmentation and dispersion of initiatives, which are usually the rule. Despite frequent declarations of commitment to coordination, this frequently proves to be an elusive goal. Endless discussions within the donor community may sometimes achieve little. And coordination is most needed where the government is weak, i.e. in situations where it is more difficult to attain.

Planners should be aware of the limited capacity of any single player (including the MoH) to enforce the chosen plans. Therefore, plans should be based on convincing models, sound and explicit in their rationale, and specific about ultimate goals, to be proposed to the many actors crowding the reconstruction stage. Plans should aim to inspire reconstruction, rather than to control it. Attempts by weak governments to control donor agencies and NGOs are doomed. Rather than expecting to be followed on sovereignty grounds, governments should try to build on their comparative concrete strengths, such as better understanding of field conditions, languages, local habits, and a better grasp of historical processes. These assets should enable governments to conceive realistic and convincing policies, built on solid information, which may provide a framework for all actors, and be followed by donors and NGOs, even when governments are unable to enforce their implementation. In fact, some donor agencies may become committed supporters of policies conceived by government, provided it appears consistent in pursuing them.

Strong, consistent leadership by the MoH may be essential to solidify donor support around shared goals. If national authorities are unable or unwilling to take the lead, an alternative agency, acceptable to most if not all players, should take this responsibility. Where a leading agency is missing (or many are competing for the leadership, such as in Angola), fragmentation, inefficiency and loss of direction become inescapable patterns.

7 Managing chaos

Political rationale often ignores technical advice, as has frequently happened in Angola. In Mozambique, a continuous tension between two conflicting perceptions permeated the policy discussion at every level. On one side, the realistic, technocratic approach, aware of the resource shortage and weak capacity, stressed sustainability and efficiency, and proposed modest targets. On the other side, there was the confident, political, need-driven approach, which pushed for ambitious objectives, considered attainable once the war was over, by seizing and exploiting the opportunities of the peace dividend. The latter approach has an obvious appeal in transitional situations, and usually pays off in the short term, boosting confidence in peace and responding to the large, and often unrealistic expectations of the immediate postwar period. However, indulging in this approach can lead to neglect of long-term sustainability concerns, and can contribute to serious future problems. This danger can be contained by solid technical analysis (understandable to politicians and lay people alike), which highlights both the present and future costs of the choices under discussion and the available alternatives. The fertile interaction between technical and political actors has been one of the factors behind the Mozambican success story.

8 Anticipating events and future constraints

In Mozambique the reluctance to introduce paying schemes led to a widespread, chaotic

system of illegal but widely tolerated charges for health care. Imposing a cost-sharing system after years of laissez faire will bring additional challenges and probably greater resistance. In Angola, deregulation and privatisation of public health care have proceeded even further. Cost sharing has been the object of intense debate, without materialising into effective regulation.

9 Limitations of cost projections elaborated in wartime

Policy-makers and planners should be aware that costing projections elaborated during wartime tend to underestimate actual needs. As a health network expands to cover remote areas, with poor communications and absent infrastructures, reconstruction can be far more expensive than anticipated. Large hospitals, even without expansion, imply high costs, more related to their level of care than to their physical size. Also, installations and equipment left for years without maintenance may deteriorate to dismal levels, raising their rehabilitation costs close to the price of replacement. Recurrent costs are also underestimated and given insufficient weight in decision-making and planning. In a disrupted, under-financed system, “recurrent costs” may be a vague concept. Using actual budget figures for projecting future needs is misleading, whereas forecasting the acceptable costs of the system, once its operations have been normalised, is difficult. The instability that characterises conflict and transitional situations also makes estimates rapidly outdated. Although the need to include recurrent costs in estimates is often highlighted, the limitations outlined here may explain why such costs are often unavoidable or misleading.

10 Short-term solutions versus long-term effects

There is no rapid solution to the massive disruption induced by decades of civil war and economic crisis. Governments and donors should openly reject the temptation of embarking on quick fixes, although this is politically very difficult. Initiatives in this sense should be discouraged as inefficient and disruptive to the reconstruction process. The merit of appealing solutions during wartime, like vertical programmes and supply systems, should be weighted against their long-term effects. What is gained during the crisis may be dearly paid for during reconstruction. Potentially disruptive schemes should be introduced only as extraordinary measures, financed during short periods, and withdrawn as soon as possible when normal operations can be resumed.

Emergency imperatives usually lead to operational standards that are absolutely beyond the reach of average health services. Despite the universal goal, included in most project documents, of pursuing phased, non-disruptive hand-overs, the gap is usually too large to be filled smoothly once the emergency is over. Local managers inherit infrastructures, equipment, and working habits that are far beyond their resources, skills and motivation. To avoid the frequent collapses experienced when the supporting projects withdraw, more modest interventions are required from the beginning. This is often at odds with the demands for quick results and security for relief personnel, which prevail during the emergency period. The imperative to save lives and reduce suffering makes concerns about the future negligible. It is however in the rehabilitation phase, when the acute emergency is over, that many of the justifications for “extraordinary” operations and programmes become untenable.

11 Sensitivities to context

More knowledge among donors and implementing partners about the host country, its history, political dynamics and the organization of services is crucial for developing relevant and effective strategies of assistance, in both relief and rehabilitation phases. “Historical analysis of the emergency situation is necessary” (Apthorpe, 1998). The need to respond quickly to

new crises is an incentive for humanitarian organizations to rely on standard procedures and for expatriate professionals to operate “by the book”, prioritizing the operations over an in-depth knowledge of the context. Thus, experienced relief workers may be particularly insensitive to local patterns. Coming from a previous complex emergency and on their way to the next, these practitioners do not pay much attention to important country specifics.

Worse, the high cost of emergency assistance, coupled with the usual over-stretching of relief agencies having to cope with multiple crises at once, generates anxiety to close an operation as soon as possible. Serious learning about a context, and from mistakes made in that specific situation, is therefore jeopardised. In Mozambique, the presence of a network of insider professionals, knowledgeable of the country, and of a comparatively rich information and analysis base, represented for the UN humanitarian component of the peacekeeping operation and for donor agencies a comparative advantage relative to Angola, where turnover of high-level personnel (national and expatriate) was and is high and documentation is in short supply.

12 Engaging with the government

Donor judgement about the worth of the government as a partner may have significant consequences. In fact, the decision to work outside the public sector in a disrupted and dependent country weakens (sometimes fatally) an already weak administration. Serious efforts to work with the government should be made, even when perspectives are bleak. Only clear evidence of government failure or avoidance of responsibilities can justify the decision to bypass government.

Additionally, the Mozambican case suggests that the distinction between developmental and humanitarian work is necessarily blurred, and that long-term institutional approaches can be more effective than relief. In the early 1990s, the decision of the Swiss Development Cooperation to support recurrent expenditure was taken against the tide of large-scale, emergency-oriented operations. While most agencies channelled resources through NGOs and invested heavily in physical reconstruction, the SDC took the risk, in the prevailing uncertain environment, of providing budget support to the MoH. This visionary move was stimulated by concern to avert the collapse of the health sector, but was made possible by the resilience of public authorities in the midst of a protracted crisis, who looked weak but credible recipient partners. In line with good medical practice, functional rehabilitation of sector management systems started as soon as possible. Only one agency, relying on robust knowledge of the situation and willing to take risks, spotted the opportunity at that time. This paid off in the long run, whereas much emergency work was wasted or produced unsatisfactory results. The tenet that developmental activities should start only when the emergency is definitively over was disproved, by successfully strengthening recipient systems at the peak of the crisis. Later, once the transition period was over, donors have become progressively more willing to work with the MoH (even coming to nurture excessive expectations about its capacity). In Angola, diffidence has prevailed and sincere attempts to develop fair partnerships have been rare and short-lived. Whether this vicious circle can be broken in the extremely difficult Angolan environment remains an open question.

13 Human resource development

The last years of a conflict may provide a unique opportunity to strengthen the health sector’s human capital. As most health workers are concentrated in secure areas and posted to overstaffed facilities, an ambitious retraining programme, aimed at preparing them for the duties they will face once peace is secured, can be launched with almost no disruption to

service provision. Distortions in the workforce structure can be corrected, skills can be upgraded and new approaches, such as those related to PHC, can be taught. Most important, entry in a retraining programme may keep stressed health workers busy, concentrated on core professional activities and bound to the health system, thereby preventing attrition or erosion of professional skills. The upgraded health workers will be crucial once the conflict is over and health services have to expand again to cover previously inaccessible areas. Seizing this opportunity has been one of the distinctive components of the Mozambican reconstruction process.

A serious problem arises when the health sector's workforce has grown out of control during protracted periods of turmoil. This has happened in Angola because of the pressure for professional education by educated urban youth, which the public sector, short of alternatives, could not otherwise satisfy. In this situation, most health workers have received short and low-level training, and many are carrying out only ancillary tasks. To correct these distortions may demand a sustained and concerted effort and may hurt political sensitivities, particularly at local level. Aware of this gross distortion, the Angolan MoH has recently developed a strategy to correct it (*Ministério da Saúde*, 1998b). However, to implement policies aimed at restructuring a bloated workforce has proven difficult in many situations. No doubt it will be dauntingly difficult in Angola too.

14 Learning from previous conflicts and reconstructions

Whereas the need to take stock of previous historical experience is perceived as obvious by scholars, there is little, if any, evidence of lessons learned elsewhere having any influence on local decision-makers in Angola or Mozambique. Serious and protracted crises look unique to local actors, who, absorbed by their painful daily experience, may ignore or neglect experience from abroad. This understandably inward-focused view leads to the search for original, indigenous approaches, which may eventually result in the rediscovery of concepts already known elsewhere.

In Mozambique, the groundbreaking study of the Ugandan reconstruction process (Macrae et al., 1993) was largely ignored, despite the several important analogies between the two countries that a dispassionate analysis could have identified. In Angola, attempts at conveying the lessons learned in Mozambique tend to fall on deaf ears or even to cause resentment. To stressed insiders, differences usually weigh more than similarities. Without learning, and dissemination of that learning, no effective response to crises can be expected. However, learning in a disrupted environment is difficult even for committed practitioners, as documentation is lost and key actors move to other duties or countries. This is apparent in the Angolan situation, in which tracing back events and experiences is very hard. In the case of Mozambique, events have been partially documented, even if many important pieces of evidence are irretrievably lost. A more prospective approach is needed for crises to come, in which analysis and documentation should start at their onset and continue in a sustained way. Lessons learned elsewhere should be made available, and translated in a context-sensitive way, in order to make sense to all actors, particularly to local ones who can be unfamiliar with the relief field.

10 Conclusions

The preceding chapters have highlighted the main features of the health sectors of Mozambique and Angola, studied within the turbulent contexts of the two countries. The resulting picture is of striking differences at all levels. Broad lessons to be retained from this analysis include the following.

First, when there is a genuine underlying drive towards peace and reconciliation, health can play a catalytic role in the peace process, accelerating and strengthening it. In Mozambique, the sector recovery was a visible success, spearheading and giving credibility to the whole peace process. But health can play this positive role only if a previous sustained investment in the sector has made it politically significant to contenders. Where there is no willingness to pursue peace, even heroic efforts in the health sector are likely to fail. The role left to health is merely damage control, to limit further deaths and suffering. In Angola, recovery never started, or stalled because of mistrust, reinforced by outbursts of violence. Health initiatives resulted in a low-profile failure, within the global collapse of the peace process.

The chosen approach to health development depends, therefore, on the informed reading of each political situation, rather than on principled strategies or guidelines elaborated far away. The attention paid by contenders to service provision can be taken as a sensitive indicator of the seriousness of a crisis. The commitment of the Mozambican government to health services confirmed the viability of the state. When the fight is to the last, or has degenerated into predatory warfare deprived of political goals, health is inevitably sidelined. This explains why health can contribute in a sustainable way to reconciliation, mainly when the war effort is at its end, as occurred in Mozambique. During conflict, or in its short lulls, positive instances of the sector capacity to promote peace, of which there are a few examples reported or documented in Angola, are easily annihilated by more powerful interests and forces.

In light of the above considerations, the concept underlying the programme under which this study has been carried out could be questioned. There seems to be an uncritical acceptance of the fact that the health sector is in a good position to play a positive role in conflict prevention and reconciliation. Health is perceived to have universal and neutral goals, to be achieved with technical (and therefore apolitical) means by committed professionals. The “new” wars, however, do not recognize, let alone respect, universal rights and conventions. On the contrary, violence against the civilian population may be an important aspect of the prevailing strategy. In this perspective, the health sector represents therefore an obstacle or even a target, as RENAMO understood and practised on a grand scale. This is one reason why positive interactions between health and peace have been documented in several reconstruction contexts, whereas much lesser evidence is available on the positive role of the sector in conflict prevention and mitigation.

Second, in the long term, government passivity rarely pays off. In fast-evolving transitional situations, to wait for more propitious environments may result in missing unique opportunities. Looking forward and taking risks are mandatory, but likely to succeed only when informed by robust analysis. Conversely, the customary donor activism in the absence of a comprehensive, locally owned strategy is likely to generate inconsistent, short-lived and even counterproductive outcomes.

Third, conflict and post-conflict situations tend to become overcrowded with multiple actors who enjoy considerable autonomy and are inclined to pursue their own agendas oblivious of what happens around them. Investment in information and intelligence, aimed at composing a reliable picture of the whole health sector and of its evolution over time, is paramount to redirect actors, to reduce fragmentation and to promote consistence of initiatives.

Fourth, sensitivity to and pursuit of knowledge of local contexts, in order to build on local strengths, are preconditions to successful interventions. The complexity and the political characteristics of the prevailing complex emergencies, and the enhanced role of aid actors in “un-strategic” conflicts call for new expertise among humanitarian workers. Technical competence and field experience are no longer sufficient requirements of health professionals if they are not sustained by the capacity to analyse the context of the country in which they are operating. Beyond the economic, social and cultural analysis, which should always be central to sound public-health practice, elements of political, military and strategic intelligence are required.

Finally, several policy lessons derived from the Mozambican case could be adapted and usefully generalized to Angola and other war-affected countries, if and when a peace settlement is reached. In Mozambique, failed efforts, counterproductive interventions and the waste of scarce resources could have been partially avoided if the available documentation on experiences of other post-conflict sector recoveries had been more widely circulated and studied, and if the attitude of both the MoH and aid agencies had been more open to and humble in learning from other contexts.

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Chronologies 1975 to 2000

Angola		Year	Mozambique	
General	Health-related		General	Health-related
<ul style="list-style-type: none"> • Independence. • Massive flight of Portuguese settlers. • Nationalisation of social sectors, law and rented property. • The three existing nationalist movements (MPLA, FNLA and UNITA) start immediately fighting for predominance, with outside support. The People's Republic of Angola is proclaimed by MPLA and recognized by the UN and most countries. The MPLA controls most of the country. • Civil war continues with involvement of South Africa and Cuba. • Central planning is introduced. 	<ul style="list-style-type: none"> • Nationalisation of health services. • Primary health care (PHC) is formally endorsed, but soon fragments along vertical lines. 	1975	<ul style="list-style-type: none"> • Independence. • Massive flight of Portuguese settlers. • Nationalisation of social sectors, law and rented property. 	<ul style="list-style-type: none"> • Nationalisation of health services. Primary health care (PHC) is adopted. • Most of the Portuguese doctors leave the country. • Health expenditure increases significantly. • Coverages and outputs expand. • Training is accelerated, and new, PHC-oriented categories of health-care providers are created. • A progressive national drug policy is introduced with remarkable success.
<ul style="list-style-type: none"> • US congress passes the Clark Amendment (remained in force until 1985), banning military aid to anti-government forces, without congressional approval. • The national oil company SONANGOL is established. 	<ul style="list-style-type: none"> • Progress in the expansion of services is slow; stated policies are only partially implemented. • Private medicine is banned. 	1976	<ul style="list-style-type: none"> • UN sanctions against Rhodesia, fully endorsed at a very high cost for the domestic economy. The Rhodesian military creates the MNR (future RENAMO). 	
<ul style="list-style-type: none"> • An attempted putsch from within the MPLA is quickly and ruthlessly repelled. • MPLA is transformed into a Marxist-Leninist party. 		1977	<ul style="list-style-type: none"> • Centrally planned economy chosen by the FRELIMO Third Congress. 	<ul style="list-style-type: none"> • <i>Lei da Socialização da Medicina</i>

Angola		Year	Mozambique	
General	Health-related		General	Health-related
		1978	<ul style="list-style-type: none"> • Rhodesian attacks in central and southern regions. • Financial inflow, with credits obtained from Eastern and Western countries. GDP expansion until 1982. • Modernisation and forced villagization campaigns. • The government, seeking to control the impending crisis, progressively introduces more authoritarian measures. 	<ul style="list-style-type: none"> • A successful mass vaccination campaign is carried out (coverage above 80%).
<ul style="list-style-type: none"> • Agostinho Nieto dies. He is succeeded by José Eduardo dos Santos. 		1979		<ul style="list-style-type: none"> • EPI reaches national scale. The MCH programme is progressively introduced.
<ul style="list-style-type: none"> • Ronald Reagan is elected president of the US. 	<ul style="list-style-type: none"> • Only an estimated 30% of the population have access to health services. 	1980	<ul style="list-style-type: none"> • The National Census returns a population slightly above 12 million. • Independence of Zimbabwe. • RENAMO passes under South African tutelage. Its military activities expand. 	<ul style="list-style-type: none"> • The expansive thrust suffers from inadequate management capacity and capital shortage. The expanded health network is mainly composed of basic-level facilities, with low-level staff delivering rudimentary health care. Despite its inadequacy, the National Health Service vastly outstrips the internal resource basis and proves unsustainable without donor support.
<ul style="list-style-type: none"> • South Africa starts a major military offensive in southern Angola. • Cuba sends additional army troops, teachers and medical staff. 		1981	<ul style="list-style-type: none"> • South African raids against ANC targets in Maputo. 	
		1982	<ul style="list-style-type: none"> • A major drought hits southern Mozambique. 	<ul style="list-style-type: none"> • The National Health Service (NHS) becomes a military target.

Angola		Year	Mozambique	
General	Health-related		General	Health-related
<ul style="list-style-type: none"> Major military operation - Operation Askari - of South African forces. 		1983	<ul style="list-style-type: none"> Economic crisis. The 4th Congress partially recognizes the failure of the socialist experiment. However, the government, grappling with an unmanageable war, worsening economic crisis and the drought, is unable to implement radically corrective measures. Gross violations of human rights (such as in the <i>Operação Produção</i>, the forced removal of unemployed people from cities) compound the crisis and jeopardize the ruling party's popularity and legitimacy. 	<ul style="list-style-type: none"> Internal financing shrinks. Coverage contracts. 100,000 deaths estimated due to famine.
<ul style="list-style-type: none"> A cease-fire plan is signed in Lusaka between South Africa and Angola, but is not implemented. 		1984	<ul style="list-style-type: none"> Mozambique is admitted to IMF and WB. Nkomati accord with South Africa. Total external debt reaches US\$ 2.9 billion. 	<ul style="list-style-type: none"> Fragmentation of health services along vertical lines. Proliferation of emergency-oriented projects. The NHS, struggling for survival, becomes largely dependent on external aid for its basic functioning.
<ul style="list-style-type: none"> War escalates into high-technology confrontation with major offensives by both sides. 	<ul style="list-style-type: none"> First donor conference: affected population estimated at 0.5 million. The health sector is allocated 3.3% of GDP. 	1985	<ul style="list-style-type: none"> Major escalation of the civil war. 	
<ul style="list-style-type: none"> The US Government officially increases financial and logistical support to UNITA, after the repeal of the Clark Amendment in 1985. 		1986	<ul style="list-style-type: none"> A RENAMO offensive in the Zambezi valley signs the high-water mark of its military success. Zimbabwe and Tanzania send more troops in support of the government. Strong tensions with Malawi, used by RENAMO as logistic basis. Samora Machel dies in a mysterious plane crash over South Africa. He is replaced by Joaquim Chissano. 	
<ul style="list-style-type: none"> South Africa formally admits its military presence in southern Angola. The first structural adjustment plan (SEF) is launched with little success. 		1987	<ul style="list-style-type: none"> Introduction of PRE, a structural adjustment programme. The government army recovers the initiative. 	
<ul style="list-style-type: none"> The Cuito Cuanavale battle ends after 8 months, with the withdrawal of 	<ul style="list-style-type: none"> Second donor relief conference: affected population estimated at 1.5 	1988	<ul style="list-style-type: none"> Donor dependence increases: aid agencies and NGOs pour into the 	

Angola		Year	Mozambique	
General	Health-related		General	Health-related
<p>South Africa.</p> <ul style="list-style-type: none"> An agreement is reached between South Africa, Angola, Cuba and USA on Namibian independence and withdrawal of Cuban troops (monitored by UNAVEM I). Gdabolite peace talks between government and UNITA, but the cease-fire breaks down. 	<p>million.</p>		<p>country and take the lead.</p>	
	<ul style="list-style-type: none"> UN-government emergency appeal. USAID emergency needs assessment in a UNITA area. 	1989	<ul style="list-style-type: none"> Military stalemate: no side stands a chance of winning an outright victory. Apartheid in South Africa is progressively dismantled under new president Frederick de Klerk. 	
<ul style="list-style-type: none"> New peace talks start in Portugal. MPLA Central Committee endorses a multiparty system. An economic liberalisation programme (PAG) is launched. Angola is admitted to the World Bank. 	<ul style="list-style-type: none"> A UN Special Relief Programme for Angola (SRPA) is launched. The sudden withdrawal of Cuban specialist doctors paralyses major hospitals across country. 	1990	<ul style="list-style-type: none"> The Naparama movement (a voluntary army relying on traditional beliefs in its war approach) tilts the military balance in favour of the government. First direct peace talks between the government and RENAMO in Rome. New multiparty constitution approved. The progressive removal of price subsidies induces strikes and protests. Nelson Mandela is freed from jail. 	<ul style="list-style-type: none"> The MoH prepares plans for reconstruction, attracting donor interest and substantive support. Sector budget support, funded by the Swiss Development Cooperation, is introduced.
<ul style="list-style-type: none"> Bicesse Accord is signed in Lisbon; amnesty for political prisoners; new multiparty constitution passed. UN Verification Mission (UNAVEM II) deployed. A system of multiple exchange rates is introduced to limit inflation; devaluation of kwanza. Between 1986 and 1991, the US covert aid to UNITA is estimated at US\$250 million. 	<ul style="list-style-type: none"> Aid agencies and NGOs expand their scope and activities. 	1991	<ul style="list-style-type: none"> Peace negotiations continue in Rome. The worst drought of the century hits Southern Africa countries. 	

Angola		Year	Mozambique	
General	Health-related		General	Health-related
<ul style="list-style-type: none"> • The demobilisation of both armies and the constitution of a unified army begin. • Internationally monitored elections are held and declared fair and free by international observers. The MPLA wins, but UNITA rejects the results. • New civil war. UNITA registers huge gains. • Inflow of foreign NGOs and emergence of indigenous ones (authorized by a law passed in 1992). 	<ul style="list-style-type: none"> • New legislation re-establishes the practice of private medicine. • The provision of basic services in rural areas becomes increasingly dependent on NGO resources and initiative. 	1992	<ul style="list-style-type: none"> • Joint Declaration by government and RENAMO on the Guiding Principles for Humanitarian Assistance. • Peace agreement signed. • Peacekeeping operation (ONUMOZ) deployed to Mozambique, including UNOHAC, the humanitarian component. • Total external debt reaches US\$5.8 billion. 	<ul style="list-style-type: none"> • Rehabilitation of the health network starts. • Health services return to previously closed areas. • Private practice is reintroduced. • NGOs provide basic PHC in RENAMO-controlled, previously inaccessible areas.
<ul style="list-style-type: none"> • The government army reorganizes and slowly recovers the upper hand. • The USA recognizes the Angolan government. • Sanctions (including arms embargo) against UNITA are declared by the UN. • The war continues with huge destruction and human losses. • The humanitarian branch of the peacekeeping operation (UCAH) is established. • Peace talks start in Lusaka. 	<ul style="list-style-type: none"> • Health services shrink as a result of worsened security and destruction of infrastructure. • Emergency Plan for Humanitarian Assistance prepared by UCAH; eventually approved by the government and UNITA. • Consolidated emergency appeals (one in 1993, two in 1994) issued under UCAH's coordination. • 610 deaths caused by cholera are reported. 	1993	<ul style="list-style-type: none"> • Transitional period; progressive unification of the country under the same administration. • Demobilisation. • Planning of reintegration programmes for ex-soldiers. 	
<ul style="list-style-type: none"> • Lusaka protocol signed. • The informal economy expands. • Hyperinflation. The currency is devalued in rapid succession. • The urban population reaches 50% of the total. • Total external debt is US\$11.2 billion. 		1994	<ul style="list-style-type: none"> • First multiparty elections, won by FRELIMO; Joaquim Chissano is reconducted in office as president. • ONUMOZ winds up. • Free elections in South Africa, won by the ANC. Nelson Mandela is elected president. 	<ul style="list-style-type: none"> • Reconstruction and expansion of the NHS. More than 400 facilities are rehabilitated or built. • Skilled health workers (previously concentrated in secure areas) are re-deployed. More qualified and appropriately trained professionals

Angola		Year	Mozambique	
General	Health-related		General	Health-related
<ul style="list-style-type: none"> • A new peacekeeping operation (UNAVEM III) is deployed to monitor demobilisation and formation of a unified army. • The quartering of UNITA soldiers starts. • A new structural adjustment programme (PES) is launched with little success. An IMF staff-monitored programme is soon abandoned. 	<ul style="list-style-type: none"> • Consolidated Appeal launched by the UN Secretary-General in Luanda. 	1995	<ul style="list-style-type: none"> • Progressive normalisation, economic recovery under free-market principles. • Decentralization is endorsed by the government and slowly introduced. 	<p>gradually replace unskilled or low-level workers.</p>
<ul style="list-style-type: none"> • Savimbi rejects the offer of a vice-presidency post. • 60% of the population lives in areas administered by the government. 	<ul style="list-style-type: none"> • Modest expansion of health services, mainly donor and NGO-driven. • Laissez-faire by MoH predominant. • Provinces and districts become progressively more autonomous. • Some progress in UNITA-controlled areas, where partial integration of services takes place. 	1996		<ul style="list-style-type: none"> • The Health Sector Recovery Programme (HSRP), a WB-supported Sector Investment Programme (SIP), is launched, but its implementation is slower than expected. Due to the fast-changing environment, it becomes quickly outdated..
<ul style="list-style-type: none"> • The national unity and reconciliation government (GURN) is constituted. • The UN Observer Mission (MONUA) is deployed. • New UN sanctions against UNITA. 	<ul style="list-style-type: none"> • Assessment of UNITA health personnel to be integrated into the NHS. • Planning, coordination and implementation of the humanitarian component of demobilisation and reintegration. • Only 30% of the population has access to health services. 	1997		<ul style="list-style-type: none"> • Elements of deregulation emerge. • Health-sector reform, quality of care and consumer satisfaction come to the policy agenda. • Despite intensive dialogue and a number of initiatives, little progress in formulating a new comprehensive health policy is registered.

Angola		Year	Mozambique	
General	Health-related		General	Health-related
<ul style="list-style-type: none"> • After years of 'no peace, no war', military confrontation erupts, with a poorly planned government offensive successfully repelled by UNITA, which registers important territorial gains. • The fall of the international oil price hinders the government capacity to rearm. • IDPs increased from 4000 in 1998 to 950 000 in 1999. • The Angolan government intervenes in support to the Kabila regime in the Democratic Republic of Congo. 	<ul style="list-style-type: none"> • Return to emergency operations in war-affected, but still accessible areas. • 150 NGOs active in the health sector. • Legislation authorizing cost-recovery schemes is passed. Implementation of them, however, is slow and piecemeal. • The NHS employs 36 500 cadres, largely unskilled or with only basic training. 	1998	<ul style="list-style-type: none"> • The opposition party boycotts local elections. 	
<ul style="list-style-type: none"> • MONUA pulls out at the request of the government. • The government accelerates its rearmament and occupies UNITA strongholds. 	<ul style="list-style-type: none"> • Major polio outbreak (1 000 cases and 100 deaths notified); control measures hindered by lack of security and by population movements induced by war. • Rampant deregulation and privatisation (formal and informal): 476 private clinics found in Luanda. 	1999	<ul style="list-style-type: none"> • Democratic elections: the ruling party is re-conducted in office. Joaquim Chissano wins another presidential mandate. 	
<ul style="list-style-type: none"> • The government Army registers further progress, forcing UNITA to return to guerrilla tactics. • Oil production approaches 800,000 barrels per day. • The GoA signs an agreement with IMF for a new staff-monitored programme, which is extended in October because of limited progress in macroeconomic reforms. 		2000	<ul style="list-style-type: none"> • Cyclones and severe floods devastate swathes of the country. 	