2. Impact of the conflicts

2.1 Introduction

Angola, at 1970s was one of the most developed African countries in terms of economic infraestructures, agricultural production and industrial development. There is no statisctics that could reflect the real negative impact of the armed conflicts that the country and its population suffered. Today, the country is caracterized by food shortage, poverty of the majority of the rural and urban population. Almost 30 years of political conflicts and civil war have paralised the economic life of the country, increased the poverty of the population and created a social crises of exceptional intensity.

2.2. Poverty situation

Two surveys were carried out to assess the current profile of poverty in Angola. The 1995 survey showed that 61% of the urban population in Angola were below of the poverty line and 12% in the extreme poverty.

One of the interesting conclusions of the 1995 survey was the fact that 44,8% of the women responsible for the household were living above the poverty line compared with only 37,2% among men. This situation was inverse compared with the results of 1990 in Luanda. This change might be a result of the more engagement of women in the informal sector, selling products in the street market as well as the collapse of the salaries of the formal sector, which have more men involved.

According with National Institute of Statistics, Angola with a Human Development Index (HDI), below 0.493 has one of the lowest HDI (Table 2) compared with other countries in the world.

Table 2. Evolution of Angola Human Development Index, 1990-1996

	1990	1991	1992	1993	1994	1995	1996
HDI	0,304	0,150	0,169	0,134	0,271	0,291	0,323
Classification	110	147	139	160	155	164	160
Number of classified countries	130	160	160	173	173	174	174

2.3. Deaths and Displacement of the population

Although there is no reliable statistics, it is estimated that as a result of the armed conflicts in Angola:

- 2.160.801 have been killed;
- 300.000 persons have sought refugee in neigbouring countries;
- 1.200.000 people are internally displaced (IDPs) (February 1998);
- 70,000 are maimed due to landmines and unexploded devices and a result of the exodus of the population from rural to the urban areas;
- the urban population has increased from 15% in 1970 to almost 50% in 1995, resulting several social problems such as violence, unemployment (estimated in 45%), prostitiution and incresing of the levels of poverty.
- 3.3 million in 1997, in need of any type of assistance as a result of insecurity and trade restriction and a result of food production;;
- 942.000 in need of food assistance in 1997/1998.

Children is one of the vulnerable groups. It is estimated that there are in Angola approximately:

- 50,000 war realted orphan children;
- 15,000 children abandoned in 1990;
- 6,000-14,000 street children living in urban areas.

Several problems have been faced by the displaced population when are resettled in some to new accommodation places. The majority of the displaced population lost their personal belongs, including their own land and are totally dependent from the humanitarian assistance.

Other important constraint was the accommodation of some of displaced people in camps or areas, where they did not have any relatives or even they did not have the ability to speak the local language, rather than to be accommodated or reintegrated in their own provinces where the probability to be integrated in their families could be higher. Some of them decided to not invest in the new places waiting for the opportunity to be send to their own provinces.

Despite the political dificulties UNHCR estimates that some 120,000 Angolan refugees have spontaneously returned to Angola between 1995 and September 1997.

2.4. Impact of the war in the health sector

(a) Health infrastructures and health care coverage

Although the limited information available, there was a significative reduction of the health care infrastructures as a result of the massive destruction since the decades of 80s. In some provinces approximately 70% of the health infrastructures were destroyed (78% Bie to 88% Uige and Lunda Sul). In Table 3 area summarized the number of infrastructures destroyed from 1990-1993 in the other provinces. Within the 11 provinces were data is available it is estimated that there are 1 health unit for 12.000 inhabitants (range 4.500-108.000). However there is no information available on the health units administered by UNITA.

Table 3. Number of Health facilities destroyed from 1990-1993

Province	1990	1993
Bengo	195	121
Benguela	250	137
Bié	92	63
Cabinda	127	25
Kuanza-Sul	133	75
Malange	104	57
Moxico	79	56

As a result of decreasing the geographic accessibility of the health units, there is an increase in the number of private clinics since 1992 , when the law was approved. Only in Luanda there is approximately 272 private clinics in January 1998. Some of them are operating without very little quality and control.

(b) Life expectancy birth

According to the MICS the life expectancy in Angola is estimated in 42,4 years (44,2 for women and 40,7 for men). Angola has the fifth lowest life expectancy in the world, where the mean in the Sub-Saharan Africa is 51 years. This low life expectancy is related to the direct effect of the war as well as a result of the diseases related with the poverty created by the war.

(c) Morbidity and mortality rates and causes

The IMR5 in Angola was estimated in 1992 at the beginning of the third war, in 274 for 1000 live births, meaning that a one fourth of the children die before

achievement of 5 years old. This is also a reflex of the quality of health care, including the accessibility and affordability which has been deterioration since the beginning of the 1980s. Usually the IMR5 is grater in the rural areas compared to the urban areas due to low education level of the rural population, as well on the accessibility to the health care. However since 1989-1992 there was not difference in the IMR5 between urban and rural areas in Angola. This could be related to the incapacity of the urban health services as well the overcrowding of the sub-urban areas without basic living conditions, and accessibility to water supply and sanitation.

According to the Ministry of Health, the major causes of deaths between 1991-1995 for all ages, were:

56% - **malaria**; 18% - diarrhea, 8% - measles; 6% - ARI

Malaria was during the same period responsible for 56% of all deaths registered for all ages. The prevalence rate of *Plasmodium Falciparum* was estimated in 38% in a survey carried out in 30 communities in Sumbe. In 197 patients in a hospital in Luanda was found 17,4% resistance to chloroquine R2 and R3 in 1997.

The diarrhea diseases and the respiratory infections are also common causes of morbidity and mortality In a study, 40% of children between 6-23 months had an episode of diarrhea in the last weeks. It was not found any difference between the rural and urban areas in terms of the prevalence of diarrhea, which corroborate what was already mentioned about the poor living conditions in the urban areas.

The number of cases of **Poliomyelitis** have increased from 14 cases per year between 1974-1988 to 86 cases between 1989-1994, with a pick of 170 in 1993. As a result of the little capacity to expand the immunization programme all over the country as a result of the war situation in the country, the average of polio coverage all over the country was only 20-30% in 1997

The **trypanosomiasis** is another example of the impact of the war on health. In 1975 only a few cases were diagnosed, with only 3 cases reported out of 500 000 people in risk of infection. Today trypanosomiasis is a threat for approximately 3-4 million persons There is approximately 100.000 patients, with a prevalence of 2.5% in the endemic zones. Only in 1997, were registered 7.522 cases, which might be only the top of the iceberg, due to the fact that the majority of the population in risk is living in areas with difficult accessibility and without health units with capacity for diagnosis.

Sexually Transmitted Diseases:

STD, particularly gonorrhea, syphilis, hepatitis B are one of the important causes of morbidity in the major urban areas. Since the diagnosis of the first AIDS cases in Angola in 1985, it were already reported 2,700 AIDS cases, although this figure thus not reflect the reality of the country due to the little capacity of diagnosis. Studies carried out in the country shows that the prevalence among pregnant women is 8% in Cabinda, 15% among patients with TB. The HIV situation will certainly aggravate in the coming years due to the current movement of the population all over the country, the movements of the refugees from the neighboring countries back to the provinces; the little utilization and accessibility to condoms; poor knowledge of the population in particular the most vulnerable groups, such as youth, commercial sexual workers, military. The KAP studies carried out in some provinces characterized well the limited knowledge about the modes of transmission of STD/HIV as well as about the mode of prevention KAP studies among adolescents and commercial sex workers, have show that only 25% used condoms during occasional sex intercourse.

Other important aspect is the capacity of screening blood. Due to the high number of blood transfusions that has been made all over the country associated to the incidents associated with land-mines, cases severe of anemia, is an important risk factor to increase the spread of dissemination of STD, particularly HIV and HBs. In the Luanda National Blood transfusion Center HBs was prevalent in 1996 in 16% of volunteer blood donors.

As a result of the rate of unemployment, the phenomena of professional blood donors is increasing, which will aggravate the HIV/AIDS situation.

Maternal Health

The current estimate for maternal mortality is 1.281 maternal deaths per 100.000 live births, according with a study carried out in 1993 in Luanda. This figure is one of the highest in the world. Approximately 83% of the deliveries are at home (72% in the urban areas and 91% in the rural areas). This another example that shows the little coverage and utilization of the health services.

Malnutrition

As a result of difficulties of providing food to the most remotes areas, associated of the problems to have access to the land due to the spread of mines, the number of cases of severe malnutrition increased in the last years. During the conflict after elections in 1992-94 the levels of malnutrition acute was 19%-44% in those areas most affected by the war, particularly in Malange In this province during this period and due to the interruption of the humanitarian assistance, the global malnutrition

rate in children bellow 5 years was 34% (20% severe malnutrition) in 1993. In May 1994 an after the initiation of the food assistance, the rate was reduced to 7%. This is an example how the current situation of communication and accessibility to the areas that need more support, can aggravate the already delicate health situation of the population, particularly the most vulnerable groups, such as children and women

(d) Children victims of land-mines, traumas, violence

Land mines and other explosive materials are responsible for 15% of all deficiencies in children in Angola. It means that approximately 11.000 children between 0-18 years old had deficiencies related with war in 1996, in a total population of 105.000 deficiencies related with war

Only land-mines are responsible for 3% of deficiencies in children. One in each 430 Angolans has a deficiency originated by a land-mine. One of the largest proportion in the world after Cambodja.

When UNITA troops were located in QA, approximately 8.470 had less than 18 years old, and 519 within the Government side Out of 1.033 children demobilized from the QA of UNITA:

- 21% had between 13-16 years old;
- 21% had the second level of education;
- 48% had lost their parents.

A great number of adults and children have past several years of intense traumas, tensions, been exposed to severe violence, out of their families.

Among 200 children seriously affected by the war in Bié, Luanda and Humabo:

- 27% lost their parents;
- 94% have been exposed into attacks;
- 66% saw explosions of mines;
- 65% had to escape to prevent to be killed;
- 10% had participate in combats;
- 7% used guns;
- 66% saw people to be killed;
- 67% saw persons being tortured.

In a survey (CCF, J-1997a) among 100 children randomly selected out of 7 042 children participating in the Project for Training Children with Traumas related to war, it was found that:

- 66% had nightmare;
- 54% fear about everything could happen,
- 26% problems in concentration,

(e) Human Resources

It is currently estimated that the Ministry of Health has 15.000 workers (5% professional staff, 20% medium level and 65% basic level) However and as a effect of the war the military health services had increased their own capacity. Approximately 60% of the national doctors are working in the military health services

Due to the war, a great number of medical doctors moved from the provinces to the capital. Luanda that has approximately a quarter of the total population of the country had in 1997, 50% of all staff of the Ministry of Health It is estimated that 10.000 health workers have moved from the provinces to Luanda. Currently it has very difficult to send new graduate doctors to the provinces. At the beginning of 1998 there were approximately 100 medical doctors in Luanda, working in the private clinics and other sectors.

3. Health Relief, Rehabilitation and Development Actions

3.1. Introduction

The current situation in Angola, may be described as one of transition. Although it was already mentioned that the current political and military situation is complex and volitile, progress in the peace process since 1997 have been achieved, supported by the international community efforts allowing a gradual transition from a situation of intense emergency to rehabilitation, reconstruction and development.

3.2. United Nations Role

Since the begining of the United Nations Assistance to Angola in 1985 to assist with food deficet caused by the conflict, covering needs of approximately 500,000 Angolans. In addition of UNAVEM II and III which mandate was to mediate the crisis and monitor the implementation of the peace process, several UN agencies have been working in Angola to support the major needs of the Angolan people. Among those agencies are the

- The United Nations Development Programme (UNDP);
- The United Nations Children's Fund (UNICEF);
- The United Nations Humanitarian Coordination Unit (UCAH);
- The United Nations High Commissioner for Refugees (UNHCR);
- The World Health Organization (WHO);
- The World Food Programme (WFP);
- The Foof and Agriculture Organization (FAO);
- The United Nations Population Fund (UNFPA);
- The United Nations Education, Science and Culture Organization (UNESCO);
- The International Labor Organization (ILO);

The World Bank (WB);

The International Organization for Migration (IOM) plays a role in the UN system

The United Nations intervention in Angola endevours to assist in:

- ✓ contributing to consolidating the peace process;
- ✓ supporting and assisting macro-economic and governance reforms along with required institutional building;
- ✓ carrying out humanitarian initiatives target directly at the war-affected populations aimed at the elevation of human suffering and facilitating the rehabilitation of local communities.

As part of the cooperation and inter-agency collaboration with the Angola Government, most of UN Agencies have protocols with a responsible sector of the Government entity and projects are reviewd and approved by the relevant line ministries before implementation. This type of collaboration is fundamental particularly in a complex political, military and social transition face that the country is living. Some of the coordination mechanisms developed are principaly:

- The Resident Coordinator System: composed by the Representatives of all UN Agencies operating in the country. The chairperson is the Resident Representative of UNDP; the moajor role is to assure a coherent and complementary actions amongst UN interventions in the country and programme development.
- The Humanitarian Coordinator: the major mandateis coordination the provision of humanitarian assistance to the civilian population in need;
- The National Humanitarian Coordinator Group (HCG): Established in 1995 by the Joint Commision, has its main mandate to monitor the humanitarian programme in Angola, definition of policies for effective implementation and solutions for the obstacles arising during the process of implementation. The HCG is chaired by the Minister of Social Assistance and Reinsertion (MINARS).

Brief description of mandates of the UN Agencies operating in Angola:

UNDP: its main mandate is to help in efforts to achieve suatainable human development focusing in Post-conflict assistance; Poverty erradication and Governance including Economic Management. In 1996-1997 UNDO disbursed US$29 million to support the implementation of national programmes; One recent programme coordinated by UNDP is the UN Joint Programme for HIV/AIDS (UNAIDS), which has the mandate to support and coordinate the development

ot programms involving the six co-sponsoring funding agencies and support the national authorities in STD/HIV/AIDS prevention and control programmes in order to achieve a national expanded response;

UNICEF: advocacy for the protection of children's rights with special protection for the most disadvantaged children, in extreme poverty, victims of war, violence and exploitation and those with disabilities; succesfull programmes were implement in 1997 mainly in National immunization Days for polio irradication, AIDS prevention and malaria;

UNHCR: repatriation and reintegration of refugees and IDPs creating absorptive capacities in major returnee areas and promoting restaurationof suatainable basic services in areas of more needed;

WHO: supports the National Health System through training; policy development; control of trasmissible diseases; support the PHC system ; continued assistance to UCAH to respond to emergency situations. WHO supported the demobiliztion process in the assistance of all health interventions in the Quartering Areas (QAs). The UNAIDS Theme Group is currently chaired by the WR; promotion of regular meetings with MoH, NGOs UNITA to share the epidemiological information from the different sides of the country, particularly the data collected in the QAs.

WFP: to facilitate the transition to more target food aid interventions in support to resettlemnt, reintegration and rehabilitation, while provide relief to displaced and war affected persons; support road and bridges rehabilitation projects; supporting demining activities and iodine deficiency with collaboration with UNICEF, With the WFP air service have been supporting humanitarian organizations, donors, Governement and UNITA to acess to the programme areas to respond to emergency needs and rehabilitation programmes;

IOM: Support in the return and resettlement assistance to demobilized soldiers and their dependants and assistance to MINARS in the return and resettlement of IDPs. All demobilized soldiers and all families of FAA, incorporated soldiesrs recived and IOM Reintegration Kit comprised clothes, tools, agricultural inputs and kitchenware, to assist them with their immediate pos-demobilization reintegration needs;

UNFPA: Expansion and integration of improved quality maternal health/Family Planning services and population sensitization through outreach activities and formal educational system. from 1991-1996 US$8.5 million were used to assist the implementation of programmes;

UNESCO: With a permanent office since 1997 in Angola. Some specific areas of intervention in 1998 are· support the UNAIDS activities in collboration of the Ministries of Education, Culture and Health on educational activities as well

with collaboration of Unicef, WHO and UNFPA; emergency education with support of Unicef utilising NNESCO's Teacher Emergency Package;

World Bank: Since 1989, Angola received ten loans from IDA totalling US$275 million. The WB initiatives include training in macro-economic management; private sector development, social policy, demobilization, resettlement and sectoral issues such as water supply and sanitation; Infraestructure Rehabilitation Projects,

UCAH: Created in 1993 specially to assist the humanitarian needs In 1995 begin the coordination of all humanitarian issues related to the quartering and demobilization of ex-soldiers from FAA and UNITA; As part of the end of the peace process, UCAH is gradually passing the responsabilities to MINARS and to UNDP. It is expected that UCAH will be phased out by the begining of 1999.

FAO: Supported the Ministry of Agriculture for the coordination and provision of technical assistance to the NGO's involved in assistance to the agricultural sector.

MONUA: replaced UNAVEM III on July 1, 1997. The mandate is to assist the Angolan parties in the consolidating peace and national reconciliation creating a long term stability and rehabilitation of the country Included monitoring the observance of cease fire and the demilitarization of UNITA, mediation between UNITA and the Government; monitoring the normalization and expansion of the state administration, promotion of human rights and the investigation of alleged human rights violation and the onitoring ad verification of the disarmed of the civilian population.

3.3. The Role of Humanitarian Aid

(a) Should the Humanitarian Aid continue?

For the following reasons there is still a room to require the continuation of the humanitarian aid in Angola, mainly due·

- The Peace Process fragility associeted to the persistent mistrust between the Peace Accords signatories;
- The need for the current peace process be carried out with humanitarian support;
- The extreme inbalance between humanitarian aid taken to the zones that are under or out of the government control;
- The difficult conditions in which a vast part of the Angolan population still lives;

- The opening and progressive access to new regions in order to permit the assistance to populations who have never been assisted.

(b) Projects for Strengthening the Transition Process

For the last two decades the World Bank, the European Union, the DFID-UK/WHO and other donors have been helping the MOH in strengthening the institutional and management capability to respond appropriately the transition process.

The aims of these projects are·

World Bank project - Institutional reinforcement at central level of the Health Sector, particularly focused on the upgrade of the capacity of planning and financial management using the procedures and existing national legislation.

European Union - through the central component of Post Emergency Health Project (PSPE) is aimed to reinforce the institutional capacity for the external resources co-ordination, NGOs co-ordination and planning process reinforcement. At Luanda Province level, the project objective is to reinforce the municipal and provincial management capacities revitalising the Health Information System, the epidemic surveillance, the supply system regarding essential medicines and the health care regionalization.

The Health Transitional Project (HTP) - financed by DFID-UK and carried out by WHO at central level provides support the strengthning the national health policy and planing capacity in 7 provinces (MINPLAN/UNICEF 1998 e MINSA 1997[i]).

(c) The NGOs Role

There is currently registered **385 NGOs** (312 nationals and 75 international). The proliferation of national and international NGOs in Angola was mainly determined by either natural or human catastrophes, such as the drought which hit the country in 1985, the cholera epidemic in 1987 and the consequences of the 20-year long armed conflict. Most of them are involved in humanitarian aid and support in the emergency situation, particularly to those affected by the war, namely children, women, the elderly, displaced people, refugees and war disabled persons (PNUD 1997). However in 1997, out of the international NGOs, UCHA controlled the activities of only 96 national NGOs, which only 55 were affiliated to the UN. Only 30 of them, had sustainable programs (UCAH 1997).

With improvement of free circulation in the country, at the end of last year, the NGOs programmes were expanded to the areas previously out of State Administration control.. However, most NGOs still have their actions strongly directed to emergency and humanitarian activities with the objective of facilitating the re-integration of the internal displaced people and demobilised soldiers.

Areas of NGOs interventions

According to the report of the WHO Consultancy (Carvalho, et al 1997), 86% of the national and international NGOs claimed to have carried out rehabilitation and provision of equipment to health units at PHC level. Approximately 79% have been involved in diseases control and provision of medicines; 76% held health educationa and training; 69% vaccination; MCH/FP programmes (36%); 55% for sanitation and 45% to water supply.

The support to the admnistration of health units occured by 48% and the activities related to the institutional reinforcement of the management of the health sectors by 52%. The operating of the health information system was referred to by only 29% of the NGOs (Carvalho, et al 1997).

Main constraints and positive aspects encountered by NGOs

Among the main constraints, the NGOs mentioned :

(a) insecurity as the main constraint; (b) restriction of movements due to land-mines throughout the territory; (c) the vague stance of the Peace Process; (d) urban delinquency; (e) difficult geographical accessibility to intervention areas; (f) shortage of national qualified personnel; (g) the generalised demotivation of the health personnel; (h) the institutional weakness of the local administrations.

The national NGOs have also mentioned the lack of credibility and trust by donors community, which consequently result in insufficient funding of their activities.

The main positive aspect mentioned by NGOs registered (Carvalho 1977) were: (a) the co-operation mechanisms with the government and local authorities; (b) the collaboration and partnership of the international community, UN agencies and NGOs'(c) the close link and involvement of the community; (d)the commitment and spirit of sacrifice of the NGO's personnel.

3.4 The role of Ministry of Health

In the following paragraphs we shall sum up the informal opinions and current conceptions on each structure or organization on the part of the other participants. In spite of not being an official opinion, it is the current conception which will in practice determine the participants' reactions in their daily interaction.

MOH Self-Perception - Since the independence of Angola the Ministry of Health has been the organ of the government in charge of the complex duty of legislating, regulating and executing the national health policy and ensuaring free medical care to the Angolans..

The MINSA believes that it has been tried to do the best as possible to achieve what was expected after independence However the persistent conflicts and its consequences, the lack of appropriate resources, the poor management associated with the lack of motivation of the health personnel, the lack of definition and updated of the health policy and strategies, brought about the collapse of the national health system. In spite of this, the the Ministry of Health was maintained throughout the natiuonal territory to carry out preventive, curative and promotive activities.

WHO's Perception - The formulation of a national health policy is the main task of the Ministry of Health and the first important step towards the improvement of health services. However, the implementation task of the defined policies requires the analysis of the institutional resources and capacity in the sector, to allow their re-orientation with a view to reaching the results defined as priorities Here is one of the important areas where WHO could support with know-how

However the process of implementation of any policy needs the capacity to overcome problems of weak management, inertia, lack of motivation of the personnel and reluctance to innovations within the MOH. This is a real challenge that the MINSA does not seem to be ready to face taking into account the general situation in the public institutions.

Perception of the Communities of Donors and NGOs - The structures of MINSA, like the other public institutions are commonly considered to be lethargic, incompetent, corrupt and incapable of carrying out their tasks. Therefore, it is deemed better to avoid them to ensure a better success of projects.

Associated with still limited capacity to co-ordinate the activities of NGOs, some donors and NGOs preferred to bypass or simply ignore the presence of the governmental authority, the laws of the country and the local rules of the services. They establish themselves in areas selected by themselves, recruiting the best employees of the public sector, adopting their own training programmes without involvement of the local authorities Some of them also lives the country without previous information of the local authorities which creates enormous demand to the population.

4. Critical Factors Affecting Smooth Transition to Development

Among the most important critical factors affecting the smooth transition to development are.

- **Peace process** not yet consolidated; new land-mines spread in areas previously cleaned; movements of armies from Government and UNITA all over the country. This new political situation have been created in the last days new phase of instability, insecurity of the population reallocated in new resettlement areas; freeze of potential funds allocated for development projects; exit of NGOs and relief agencies from the areas in more need for humanitarian relief;

- The **low literacy rates** of the majority of the population living either in rural and sub-urban areas, creates a great negative impact in any health intervention programmes;

- The process of **rehabilitation of health and education infrastructures** is still very low; creating problems of accessibility to health care and disease prevention programmes. However the rehabilitation of the services requires not only restoration of infrastructures but an opportunity to define intervention priorities and a long term plans based on maximal use of available resources and better management capacities, supported by a human resource development and institutional development with financing support.

- The **current state budget** allocated for social services does not reflect the priority that must be given to support the development and improvement of heath care and health condition of the population; Still a great amount has been allocated for defense rather than the social and macro-economic development; there is not yet a clear policy to promote development of the rural areas in order to inverse the current imbalance between the rural and urban areas,

- There are yet thousand of **military not yet demobilized** from UNITA, which could create several social problems if the peace process terminates successfully. It will be very difficult to reintegrate them in the society and get latter on adequate support;

- Still several programmes addressed to vulnerable groups such as demobilized, refugees, IDPs, children abandoned are verticalized. As far as most of those programmes has the objective to reintegrate those groups in the society, it must be important to assure more efficiency and efficacy to the actions at community level, **empowering the communities** to deal in a sustainable way the process; the communities are seen as simple victims but not as possible actors in search of solutions to the emergency situations which hit them.

- Due to the current high living cost and the poor salaries of the public personnel the **morale is very low** which is reflected in the current level of activities and production

of the public sector This has been origination lack of credibility of the public health care system and more people have been attending the private sector with a lot of costs, based on the salaries received;

- **No strategies** were yet defined for promotion **the allocation of health professionals** particularly medical doctors to the provinces, aggravated by the current political and military situation in the country; the lack of material and other basic conditions to support the medical doctors at the provincial level;

- Little **coordination at provincial level** about the main programmes and interventions of the NGOs and international organizations with the national authorities;

- Still a very **little institutional capacity** to promote an integrated approach to overcome the current trends of morbidity and mortality causes, associated to the points above mentioned; the resettlement of the population and movements of refugees and IDPs can have a profound negative impact on disease patterns, particularly when those movements are rapid, poorly planned and little capacity from the authorities to support the process.

- The current **situation of HIV/AIDS** in the country aggravated by the social environment, return of the refugees, more movements all over the country, will aggravate the spread of HIV infection, with yet a little capacity of the state to prevent the transmission. The high prevalence in women is assumed to result from the fragmentation of traditional family structures, the lack of education and employment and the increased drift to prostitution. Although there is no written evidences, there are oral reports that the peace-keeping trops are involved in prostitution with young girls and several without condoms Although efforts have been done to attempt a national expanded response the process is still slow and the negative impact will be tremendous compared with the already infected countries in the region;

- The **Health Information System** is not yet integrated and the poor quality of data prevent the use adequately the definition of correct priorities interventions and funds allocated. The system is currently in process of review, no information about the private health sector on morbidity and mortality causes as well from the military health services which creates more problems in the health information system;

- The budget allocated for **water and sanitation** have been decreasing since 1990, and now is only 1% of the state budget This is one of the critical constraint to improve the environment conditions, not only in the rural areas but also in the sub-urban areas overcrowded;