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*Expanding family planning
and reproductive health
services in Africa*

Qualitative Factors Determining Poor Utilization of Family Planning Services in Angola: Results of the Strategic Mapping Exercise

Angola Ministry of Health,
National Office of Public Health
Advance Africa
USAID/Angola

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REPÚBLICA DE ANGOLA

MINISTÉRIO DA SAÚDE
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USAID/ANGOLA
ADVANCE AFRICA

QUALITATIVE FACTORS DETERMINING POOR
UTILIZATION OF FAMILY PLANNING SERVICES IN
ANGOLA:
RESULTS OF THE STRATEGIC MAPPING EXERCISE



LUANDA, JULY 2003

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EXECUTIVE SUMMARY

After more than four decades of conflict and civil strife, much of Angola has been destroyed and abandoned. Any development gains that were made previously have been lost. However, populations are slowly returning to their home regions as peace and security are restored. Angola is slowly emerging from its difficult past, and part of the process for this war-torn country is to initiate and implement national strategies for economic and social development. Health is a major national strategic priority, as the health of the population affects so many other sectors.

The maternal mortality rate in Angola is one of the highest in the world, with 1,850 deaths per 100,000 live births.¹ Prenatal care is not easily available and many women lack access to emergency obstetric services. The utilization of family planning services is low. Contraceptive prevalence is low, estimated to be 1.8%.¹ Infant mortality rate is very high and estimated at 195 per 1,000 births.¹ All of this data varies geographically between urban and rural areas. Only 8% of Angolan women (aged 15 to 49) have adequate knowledge of HIV/AIDS transmission and prevention, and nearly one-third of all Angolan women have never heard of HIV/AIDS. In 1999, 19% of sex workers in Luanda tested HIV-positive. Two years later, that number had jumped to 32.8%.²

Within the context described above and based on the five-year National Strategic Plan for Reproductive Health, the Ministry of Health (MOH) in Angola requested technical assistance from Advance Africa in undertaking a qualitative participatory assessment of family planning in the country. The objective of this assessment was to analyze existing health data, collect qualitative data, and reach consensus among stakeholders regarding program gaps, weaknesses, and opportunities. The Advance Africa team focused its efforts in this Strategic Mapping exercise on three provinces, Luanda, Benguela, and Huambo, which were selected as representative of the remaining provinces.

A stakeholders meeting with all major partners was also held to help identify priorities, needs, and gaps in family planning. A total of 30 focus groups involving adolescents, men, women, nurses, and traditional birth attendants were conducted. In addition, site observations were made and 21 semi-structured individual interviews with key informants were conducted in 11 locations. Persons interviewed included religious, political, and community leaders; United Nations (UN) representatives; representatives of nongovernmental organizations (NGOs); and other influential persons.

Based on the results of the Strategic Mapping exercise, key factors were found to account for the low utilization of the existing family planning services:

- Poverty, which is associated with ill health and disease, is omnipresent.

¹ Ministério da Saúde, Direcção Nacional de Saúde Pública (DNSP). 2002. *Plano Estratégico Nacional de Saúde Reprodutiva 2002-2006*. Luanda, Angola: DNSP.

² United Nations Office for the Coordination of Humanitarian Affairs (OCHA). "Angola: Youth Centres to Fight AIDS." IRINNEWS.org. <<http://www.irinnews.org/print.asp?ReprotID=35861>> (accessed Aug. 20, 2003).

- The current health care delivery system has suffered greatly due to inattention and lack of funding. As a result, the family planning services, where they exist, are inadequate and inefficient.
- Cultural and social factors contribute significantly to misinformation surrounding family planning and barriers to its use.
- Gender inequity in Angola determines that while women have the major responsibility for family care, final decisions regarding the number and spacing of children rest with men.
- The church reinforces cultural norms by preaching against modern contraceptives in a society where many children are the ideal.
- Youth are especially marginalized because they lack access to information and services.

Photo 1: Team coding the data in pairs, RH Department, MOH, Luanda

On the other hand, the assessment team also found key areas for promoting family planning within the realities of Angola. An awareness and acceptance of **birth spacing** as a positive health strategy among both men and women constitutes a key foundation for building support for family planning. The possibility of integrating quality family planning at primary and secondary health centers could also improve access for women. To accomplish this, efforts must be made to reinforce and strengthen the knowledge and skills of existing and new staff and to upgrade health centers.



Photo : B. de Negri

The challenges encountered in promoting family planning and increasing contraceptive prevalence will not be easy to surmount. Nonetheless, the assessment, which constitutes the initial step in designing an appropriate intervention, has identified four major areas for intervention. The four major areas include: 1) the quality of health services; 2) the access to health services; 3) the limited demand for family planning; and 4) the question of long-term sustainability of services. Following the Strategic Mapping exercise and presentation of the preliminary results, the Advance Africa team met with stakeholders to discuss implementation strategies that would effectively address the overall goals set by the assessment. In brief, they are:

- Integration of family planning services into HIV/AIDS and maternal and child health services
- Decentralization of family planning services to health centers and community structures

- Community involvement in the whole process of planning and implementation of family planning services
- Partnership and multi-sectoral collaboration

The implementation of these strategies with a focus on the four areas just mentioned will help the Ministry of Health in Angola to achieve the goals set in the National Strategic Plan for Family Planning.

Results from the Strategic Mapping exercise identify gaps and weaknesses in the Angolan health system. Advance Africa anticipates that the Strategic Mapping process will continue to be used to create ownership and establish partnerships in achieving the goals of the MOH.

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ACRONYMS

AIDS	acute immunodeficiency syndrome
BCC	behavior change communication
CCF	Christian Children's Fund
CPR	contraceptive prevalence rate
DNSP	Direcção Nacional de Saúde Publica (National Directorate of Public Health)
DSP	Direcção de Saúde Publica (Directorate of Public Health)
FGD	focus group discussion
FP/RH	family planning/reproductive health
HIV	human immunodeficiency virus
IDP	internally displaced person
IEC	information, education, and communication
IMC	International Medical Corps
JIRO	Informed, Responsible and Organized Youth Organization
MCH	maternal and child health
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PSI	Population Services International
STI	sexually transmitted infection
TBA	traditional birth attendant
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

I. INTRODUCTION

Angola, a country of approximately 13.5 million people, has one of the highest maternal mortality rates in the world (1,850/100,000).³ The infant mortality rate is an estimated 195 deaths per 1,000 live births.⁴ To address the reproductive health needs of the country, the Plano Estratégico Nacional de Saúde Reprodutiva 2002-2007 (National Strategic Plan for Reproductive Health 2002-2007) was adopted in 2002 based on *Prestitação de Serviços em Saúde Reprodutiva Políticas e Normas* (Reproductive Health Politics and Norms in Angola). Representatives from the Ministry of Health (MOH), the Direcção Nacional de Saúde Pública (DNSP) (National Directorate of Public Health), 17 provinces, the medical school, international agencies, and nongovernmental organizations (NGOs) were called together to develop the strategy collaboratively.

The strategy's objectives and planned activities focus on improving the health of women and men of reproductive age through quality services for prenatal care, birth assistance, family planning, sexually transmitted infections (STIs), and HIV/AIDS. Three major strategies are included in the plan:

1. Develop a strong health monitoring system with concrete process indicators
2. Implement interventions based on operational research to improve and maintain the quality of family planning/reproductive health (FP/RH) services by strengthening institutional capacity
3. Utilize social mobilization techniques with a focus on youth

Based on this National Strategic Plan for Reproductive Health, low utilization of family planning (contraceptive prevalence declined from 8.1% in 1996⁵ to 6% in 2001⁶) and the specific context of postconflict issues related to reproductive health service delivery, the DNSP invited Advance Africa to respond to the question: ***Why is the contraceptive prevalence rate decreasing?***

I.A. Objectives

The objective of the mission was to conduct a Strategic Mapping exercise—a qualitative assessment and planning exercise—to understand people's perceptions, ideas, and beliefs regarding family planning in the country; to determine priority areas for intervention to promote family planning; and to identify mechanisms for engaging community support.

³ Ministério da Saúde, Direcção Nacional de Saúde Pública (DNSP). 2002. *Plano Estratégico Nacional de Saúde Reprodutiva 2002-2006*. Luanda, Angola: DNSP.

⁴ Ibid.

⁵ Instituto Nacional de Estatística (INE) and United Nations Children's Fund (UNICEF). 1998. *Angola Multiple Indicator Cluster Survey (MICS) 1996*. Luanda, Angola: INE/UNICEF.

<http://www.childinfo.org/mics/cntry_files/ANG_MICS_1996.pdf> (accessed Sept. 22, 2003).

⁶ Instituto Nacional de Estatística (INE) and United Nations Children's Fund (UNICEF). 2002. *Angola Multiple Indicator Cluster Survey (MICS) 2001 (in preparation)*. Luanda, Angola: INE/UNICEF.

I.B. Strategic Mapping Methodology

The following briefly summarizes and describes the Strategic Mapping methodology that Advance Africa utilizes in the region to strengthen access, demand, quality, and sustainability of family planning services. Advance Africa's approach offers program managers, leaders, and decision makers a flexible way to strengthen FP/RH program implementation.

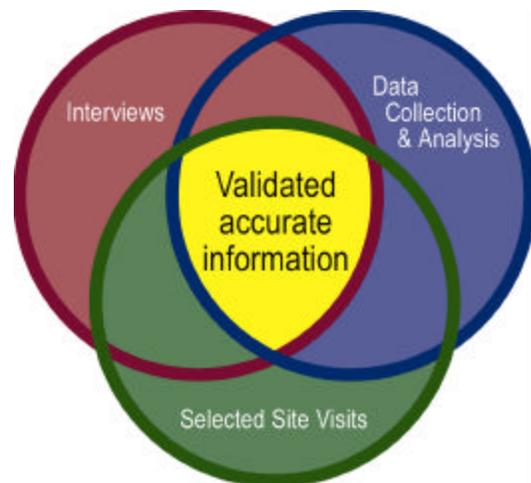
Advance Africa's Strategic Mapping approach consists of three phases:

- Participatory Rapid Assessment
- Interactive Group Planning
- Program Implementation and Monitoring

I.B.1. Phase One: Participatory Rapid Assessment

Strategic Mapping starts with a qualitative assessment of ongoing program implementation activities and the subsequent analysis of data from various sources. A multidimensional approach is used in the analysis. Therefore, a combination of published and unpublished data, interviews of selected key informants at all levels, focus groups, meetings with stakeholders, and field observations are conducted. The combined results gathered from these diverse sources are cross-matched through a triangulation process designed to retain only overlapping information (see Figure 1). This overlapping information is then validated by the assembled group of stakeholders as the most accurate information for use. The major strengths and weaknesses identified in each health or non-health facility is then summarized through an analytical grid that asks for "yes" (+) or "no" (0) responses in each area. The completed grids demonstrate the opportunities and gaps that exist in a "map" and provide a basis for group discussion at various levels.

Figure 1. Triangulation of data



I.B.2. Phase Two: Interactive Group Planning

The Interactive Group Planning phase follows the collection of data described above. This step focuses on the determination and implementation of selected actions for each identified opportunity and gap in the program. Its success is dependent on the level of participation of the key partners who have been involved in the process. Participants select and propose the most feasible and potentially effective promising and best practices to correct identified gaps and weaknesses.

An **Action Plan Matrix** is used to identify the opportunities, gaps, corrective activities, and steps necessary to complete activities for each identified gap. The completed action plan is used as a short-term plan for a period of no more than one year. It focuses the process of interactive group planning on the corrective measures, or *what to do*, for each of the selected priority gaps; the key players; the dates for completion; and the outputs, or *what is the expected performance*, for each

activity. The indicators are the means of verification, and the assumptions also cover possible constraints.

I.B.3. Phase Three: Program Implementation and Monitoring

The implementation of these action plans will be monitored on a regular basis by group members, and periodic evaluations will also be conducted to refine activities. This approach guarantees that Strategic Mapping is an ongoing process, evolving and developing as stakeholders continue to design, evaluate, and adapt action plans. As a result, activities always maintain their relevance, despite changes in the context and the environment.

II. APPLICATION OF STRATEGIC MAPPING METHODOLOGY IN ANGOLA

Using the tools in the Strategic Mapping approach briefly described above, the following report outlines the results of the Participatory Rapid Assessment and the Interactive Group Planning phases. Phase Three includes implementation and evaluation and will start upon commencement of project activities.

II.A. Phase One: Participatory Rapid Assessment of Angola's FP/RH Program

Advance Africa sent a two-person team to Angola in June 2003 to work with the DNSP of the MOH, the United Nations (UN), and NGOs in order to develop the first two phases of the Strategic Mapping exercise. The schedule in Annex 1 outlines the daily activities for the participatory assessment. Representatives from the DNSP and NGOs were selected and worked with Advance Africa to establish the research team.

Advance Africa's Strategic Mapping team conducted the following information collection activities during the triangulation process:

- Secondary data analysis and consensus-building
- Interviews with key informants and decision makers and focus group discussions (FGDs) with specific profiles of the population
- Field and site observations

II.A.1. Secondary Data Analysis and Consensus-Building

The Advance Africa team conducted a literature review to obtain relevant data on current family planning programs in Angola as well as family planning knowledge and use by the Angolan population. Data sources included published and unpublished materials from international organizations, NGOs, the MOH, and the National Statistical Institute.

Subsequent to the completion of data collection, 30 participants attended a stakeholders meeting on 3-4 June 2003 in Luanda. The major objective of this meeting was to provide a forum for decision makers and program managers to share their experience in and knowledge of family planning in Angola. As a result of this meeting, consensus was reached on four aspects of family planning service delivery: **access, demand, quality, and sustainability**. Through brainstorming exercises conducted in pairs, in small groups, and in plenary, the stakeholders meeting was able to achieve consensus on a number of important topics.

TABLE 1. MAJOR CONSENSUS TOPICS – STAKEHOLDERS MEETING, JUNE 2003	
ADVANCE AFRICA’S STRATEGIC MAPPING APPROACH: CONSENSUS BUILDING	METHOD OF WORK
Consensus on the overall family planning situation at each level and for each aspect (access, demand, quality, and sustainability); Consensus of the key priority areas for further discussion	Work in plenary
Consensus on the existing FP situation based on the key elements retained	Work done per group/by region
Consensus on the existing FP situation per region	Work done per group/by region
Consensus on the optimal FP situation	Work done per group/by region

Selection of Assessment Sites: The DNSP requested that the exercise be undertaken in three provinces: Luanda, Benguela, and Huambo. The three provinces are representative of the various economic strata of the country and population. For example, Luanda’s population lives in better economic conditions than those found in Benguela, which has a population at medium to low economic levels. Huambo, a region profoundly affected by the war, has the lowest economic status. The MOH and the research leaders agreed that the urban versus rural socioeconomic status of the provinces (including individual and governmental infrastructure) might also elucidate the different perspectives and behaviors of communities in each province.

Upon completion of the assessment, a pilot project will be implemented in one of the three provinces to strengthen family planning services as appropriate to the needs identified. After a period of one to two years of project implementation, an evaluation of the interventions undertaken will determine appropriate ways to replicate and scale up the best practices and lessons learned from pilot projects.

II.A.2. Focus Group Discussions and Interviews of Key Informants

The team developed a survey methodology based upon the basic research question, “*Why are people of reproductive age not coming to health facilities for family planning services?*” Breaking down this question assisted the research team in determining the profiles of those individuals involved in the focus group discussions and individual semi-structured interviews, as well as the framework within which these discussions would be conducted.

Prior to the assessment, the 13-person research team participated in a two-week training. The team worked in the DSNP building in Luanda, and as a result, the head of the DSNP actively participated and provided direction in the planning process. The training focused on the following:

- Conducting FGDs, strengthening skills in effective note taking, and systematizing and organizing data⁷

⁷ De Negri, B., and E. Thomas. 2003. *Making Sense of Focus Group Data: A Systematic and Participatory Analysis Approach* (in press).

- Collecting and analyzing data from Luanda province, permitting the team to practice together and arrive at a common approach

The training in Luanda provided the team an opportunity to develop guides for interviews and FGDs. Using the first FGD as a pretest, the guides were adapted for further use. The majority of the FGDs were taped. When tape recording was not possible, the team assigned two people to take notes. Partial transcripts supplemented incomplete data to help describe and interpret information. The guides for interviews and FGDs are presented in Annex 2 (Portuguese only). When necessary, team members spoke local languages and translated their notes into Portuguese. Prior to conducting the FGDs, the team agreed on key words to use while speaking local languages.

After discussions, the team members and the National Director of Public Health agreed on the following criteria for the composition of the FGDs. In Luanda, the FGD participants were:

- Women (sexually active) 20-35 years of age with two or more children, urban area
- Men (sexually active) 20-35 years of age with two or more children, urban area
- Adolescents, 14-19 years of age, urban area
- Nurses who work in the *unidades sanitarias* (health centers) and in the hospitals/maternity wards

In Benguela and Huambo, the FGD participants were:

- Women from the marketplace 20-35 years of age, with one or two children, rural
- Young men 14-19 years of age with two or more children, rural
- Men (sexually active) 20-35 years of age with two or more children, urban
- Traditional birth attendants who serve the local communities

All focus group participants had lived in the community for at least one year.

Following the training and initial FGDs in Luanda, the team split into two groups to travel to Benguela and Huambo. The members of the team are listed in Annex 3. Each provincial team worked in two sub-teams and conducted an average of two FGDs per day per region. The remaining days were devoted to organizing the raw data and completing an initial analysis of the findings.

The team decided to conduct at least two FGDs of the same profile of people, and more if necessary. The team organized, analyzed, and described the data to identify differences between the regions.⁸

In addition to FGDs, the team conducted individual interviews using a semi-structured interview guide of their own design. The interviewees were political leaders, religious leaders, decision makers, community leaders, and influential persons from the government and the UN group. These interviewees were selected because of their positions of influence within their respective

⁸ All the data has been organized in such a way that anyone interested can have access to the raw data and its preliminary analysis. Contact Maria do Carmo de Cruz, Ministério da Saúde Pública, Direcção Nacional de Saúde Pública, Luanda, Angola. Telephone: (244-2) 330-435.

spheres; the interviews were designed to elicit their opinions about the perceptions of FP/RH in the populations they serve.

II.A.3. Field Observation

Finally, as part of the triangulation process, the team conducted site visits to health centers. Eleven sites were visited in the three provinces, although in that time only two health centers were visited in Huambo.⁹ A guide was developed to help focus the observation (see Annex 4). The team took many pictures that depict the current situation in Angola, as seen in the Results section of this report.

Throughout the process, the team worked in close collaboration with the Directorate of Public Health of the Provinces of Huambo and Benguela, the International Medical Corps (IMC), the United Nations Population Fund (UNFPA) in Huambo, and the Christian Children Fund (CCF) in Benguela. The Management Sciences for Health (MSH) office and staff in Luanda provided logistical support, which was helpful to the assessment team.

II.B. Phase Two Interactive Group Planning for Angola

The Interactive Group Planning phase in Angola took a different shape than had been anticipated. The Advance Africa research team organized a half-day meeting with all of the key partners interested in FP/RH. About 50 people came from the government, NGOs, and the UN. The team presented the data collected and analyzed during Phase One (the Rapid Participatory Assessment). The stakeholders attending the meeting had limited participatory input for the simple reason that very little family planning has been implemented thus far in Angola. For this reason, many of the stakeholders were rather shocked to learn of the team's findings.

It would have been difficult at that point in time for the people attending the meeting to identify opportunities and gaps or promising and best practices because family planning is almost nonexistent in Angola. However, the participants at the meeting agreed that some promising practices could be advocated, but only after adaptation. Indeed, some attendees gave examples of positive interventions; however, the examples were mainly from Luanda, where the situation is much different in terms of support and provision of supplies than in the other provinces. The participants also concluded that in poorer and more remote areas, it would be difficult to replicate these promising practices without adaptation. It was added that contraceptive supply issues must also be taken into account before family planning interventions are designed. For example, Huambo had a negligible contraceptive supply in the health centers visited, which was not the case in Benguela or Luanda.

The group agreed that action should take place not in Luanda, where almost all the NGOs are working, but rather that an action plan should be further developed for either Huambo or Benguela. The Advance Africa team, in agreement with the government, decided to develop an action plan for Huambo. The team then drafted a preliminary plan that will be further developed in a second visit.

⁹ In August, the Advance Africa team visited 16 additional health centers in the province of Huambo. These visits confirmed that the infrastructure and the conditions of work are much worse in Huambo than in the rest of the country, as Huambo was heavily affected by the war.

II.C. Phase Three: Program Implementation and Monitoring

This phase will take place once the work plan for the pilot project in Huambo has been completed and revised by the Advance Africa team and the MOH.

III. RESULTS

III.A. Phase One: Secondary Data Analysis (Literature Review) and Consensus Building

Relevant demographic and health indicators in Angola are included in the following sections. The literature review process was both rewarding and challenging, as the team found varying results and interpretations of the same data collected during the same period of time. The rapid and fluid changes ensuing from the shift from conflict to postconflict status were also important.

The ongoing transformation of Angola is most visible in the population previously known as Internally Displaced Persons (IDPs). Currently, most of the IDPs have returned to their communities or decided to resettle in new locations, which calls into question the appropriateness of their classification as IDPs. For example, the UNFPA report, “The Trajectory of Life as Internally Displaced Persons in Angola,” published in March 2002, estimated that there were more than four million IDPs in Angola. By June 2003, however, the number of IDPs was an estimated maximum of 300,000, as many have left the camps or returned to the rural areas where they had lived before the war.¹⁰ Continuing to define all of these people as IDPs inaccurately represents the current situation.

III.A.1. Population and Age Distribution

With an annual population growth rate in Angola approaching 3%, the estimated population in Angola in mid-2003 was 13.1 million.¹¹ The population is young, with nearly half of the population under 15 years of age (49%); the median age of the population in 2000 was 15.9 years. Women of reproductive age, between 15 and 49 years old, account for 42.7% of the population. Life expectancy is higher for women (46.6 years) than for men (43.9 years).¹²

III.A.2. Socioeconomic Trends

Angola’s gross national index per capita in 2002 was US\$600.¹³ However, 61% (1995 data) of the population lives in poverty. Twenty-seven percent of the households in Angola are headed by women. Of these households, over half of these women are illiterate. The percentage of women aged 15 and older who are able to read a letter or newspaper (54%) is much lower than that of the men (82%).¹⁴ The International Medical Corps Angola/Reproductive Health for Refugees Consortium (IMC/RHR) survey in Huambo also showed a significant difference in the level of education between the sexes. For example, men attended an average of 4.47 years of school, while women attended an average of only 2.64 years.¹⁵

¹⁰ Paola Caros (Senior Resident Adviser, United Nations Office for the Coordination and Humanitarian Affairs), interviewed by Advance Africa team, June 19, 2003.

¹¹ United Nations Population Division. 2000. *World Population Prospects; the 2000 Revision*, Volume I: Comprehensive Tables.

¹² Ibid.

¹³ The World Bank Group, World Development Indicators Database. August 2003. *Angola Data Profile*. <<http://devdata.worldbank.org>> (accessed August 29, 2003).

¹⁴ Instituto Nacional de Estatística (INE) and United Nations Children’s Fund (UNICEF). 2002. *Angola Multiple Indicator Cluster Survey (MICS) 2001 (in preparation)*. Luanda, Angola: INE/UNICEF.

¹⁵ IMC Angola/Reproductive Health for Refugees (RHR) Consortium M&E Program. 2001. *Improving Family Planning Services, Huambo and Luena, Baseline Survey*. Luanda, Angola: IMC/RHR.

III.A.3. Maternal and Child Health

Estimated infant mortality rates in the year 2000 varied from 126¹⁶ to 195¹⁷ per 1,000 births. The mortality rate for children under five years of age was estimated to be 250 per 1,000 in 2001.¹⁸ However, World Health Organization (WHO) estimates for child mortality in 2001 were much higher, at 279 for females and 306 for males.¹⁹ The MOH estimate in 2000 for maternal mortality was 1,850 per 100,000 births, giving Angola one of the world's highest maternal mortality rates.²⁰ In addition, the MOH estimates that in 2000, 80% of the births in Angola took place in the home.²¹ The IMC survey in Huambo found that in 2000, 74.7% of deliveries took place in the home, with a large percentage of these deliveries assisted by a family member (29.4%) or taking place without assistance (24.4%).²² The MSH 2002 study of three municipalities in Luanda found that approximately 56% of the births occurred in a health post or health center, while 43% occurred at home (60% of which were assisted by a family member or friend).²³

III.A.4. Family Planning

The fertility rate in Angola is 6.9, again one of the highest in the world. The MOH estimates the contraceptive prevalence rate (CPR) in 2000 to be 1.8%.²⁴ In 2001, the United Nations Children's Fund (UNICEF) estimated that the CPR was 6%,²⁵ lower than the 1996 UNICEF estimate of 8.1%.²⁶ Of the women surveyed in the UNICEF Multiple Indicator Cluster Survey in 1996, only 3.5% used a modern method of contraception, yet 22.7% of women do not want to have any more children.²⁷ The 2002 MSH study in Luanda showed that 34% of women had used contraceptives or were using a contraceptive method at the time of the survey. This percentage increased with the rate of school attendance.²⁸ The 2000 IMC survey in Huambo indicated that 52% of women did not want more children or wanted to delay the birth of their next child.²⁹

¹⁶ United Nations Population Division. 2000. *World Population Prospects; the 2000 Revision*, Volume I: Comprehensive Tables.

¹⁷ Ministério da Saúde, Direcção Nacional de Saúde Pública (DNSP). 2002. *Plano Estratégico Nacional de Saúde Reprodutiva 2002-2006*. Luanda, Angola: DNSP.

¹⁸ Instituto Nacional de Estatística (INE) and United Nations Children's Fund (UNICEF). 2002. *Angola Multiple Indicator Cluster Survey (MICS) 2001 (in preparation)*. Luanda, Angola: INE/UNICEF.

¹⁹ World Health Organization. 2001. *Selected Health Indicators for Angola*.

<<http://www3.who.int/whosis/country/indicators.cfm?country=ago>> (accessed Sept 2, 2003)

²⁰ Ministério da Saúde, Direcção Nacional de Saúde Pública (DNSP). 2002. *Plano Estratégico Nacional de Saúde Reprodutiva 2002-2006*. Luanda, Angola: DNSP.

²¹ Ibid.

²² IMC Angola/ Reproductive Health for Refugees (RHR) Consortium M&E Program. 2001. *Improving Family Planning Services, Huambo and Luena, Baseline Survey*. Luanda, Angola: IMC/RHR.

²³ MSH, December 2002. Strengthening MCH Services Project, *MCH Baseline Survey*: presentation and unpublished data

²⁴ Ministério da Saúde, Direcção Nacional de Saúde Pública (DNSP). 2002. *Plano Estratégico Nacional de Saúde Reprodutiva 2002-2006*. Luanda, Angola: DNSP.

²⁵ Instituto Nacional de Estatística (INE) and United Nations Children's Fund (UNICEF). 2002. *Angola Multiple Indicator Cluster Survey (MICS) 2001 (in preparation)*. Luanda, Angola: INE/UNICEF.

²⁶ Instituto Nacional de Estatística (INE) and United Nations Children's Fund (UNICEF). 1998. *Angola Multiple Indicator Cluster Survey (MICS) 1996*. Luanda, Angola: INE/UNICEF.

²⁷ Ibid.

²⁸ MSH, December 2002. Strengthening MCH Services Project, *MCH Baseline Survey*: presentation and unpublished data

²⁹ IMC Angola/ Reproductive Health for Refugees (RHR) Consortium M&E Program. 2001. *Improving Family Planning Services, Huambo and Luena, Baseline Survey*. Luanda, Angola: IMC/RHR.

Photo 2: Working session during stakeholders' meeting

The baseline survey conducted by MSH in the province of Luanda showed that 77% of women knew about a contraceptive method, and on average, women knew of 2.4 modern methods. However, only 14.5% of women knew a traditional method. Only 2.7% of women said they did not know any contraceptive method.³⁰



Photo : B de Neeri

Women in Huambo who were asked to cite reasons for not using contraceptives responded as follows:

- 37.1% do not have contraceptive information or do not know where to go for contraception.
- 18.2% said they wanted more children.³¹

In Luanda, responses were as follows:

- 20% of women said that they did not use family planning because they wished to have more children.
- 25% said they were breast-feeding.
- 21.2% said that they did not have a sexual relationship.
- 12.6% cited fear of side effects of the method used.
- 4.8% mentioned their husbands' opposition to using family planning methods.
- 2.8% cited religious influences.
- 1.3% said cost was the main reason they did not use family planning.

Among men, there were three primary responses given for not using contraception: the desire for a large family, a lack of interest in family planning, and a lack of knowledge.³²

The 2000 UNFPA IDP study in the provinces of Huila, Benguela, Malange, and Zaire indicates that the accumulated total fertility rate in the groups studied was over 10 children per woman. However, of the respondents, about one-third said they would like to use a contraceptive method. The IDP study showed that only 13% of the women in the provinces surveyed knew of a contraceptive method, while 30% of men said they knew a method to prevent pregnancy. Of women who did know of a method, approximately one-third said they did not use contraception.

³⁰ MSH, December 2002. Strengthening MCH Services Project, *MCH Baseline Survey*: presentation and unpublished data

³¹ IMC Angola/ Reproductive Health for Refugees (RHR) Consortium M&E Program. 2001. *Improving Family Planning Services, Huambo and Luena, Baseline Survey*. Luanda, Angola: IMC/RHR.

³² MSH, December 2002. Strengthening MCH Services Project, *MCH Baseline Survey*: presentation and unpublished data

The UNFPA study found that the difficulty in obtaining services or the lack of FP/RH information was of major concern.³³

In 2002, the relief and development organization GOAL conducted a qualitative survey in two IDP camps in Moxico province. The results of the survey demonstrate that the community’s knowledge of modern methods for family planning was generally low. However, individuals expressed an interest in family planning services, and both men and women wanted information about contraceptives. Only those who worked for the GOAL project as community health motivators had basic knowledge about modern methods.³⁴

In a 2002 GOAL study, all discussion groups had a positive view regarding the importance of spacing births. One respondent stated, “*When you have another child, the first child should be able to catch or hold the new baby.*”³⁵ While this statement demonstrates that the culture believes in the importance of birth spacing, there is still a lack of knowledge regarding the benefits of birth spacing as a health intervention for both mothers and their children. The study goes on to convey the difficulties that younger women have with the traditional method of birth spacing, i.e., by avoiding sexual contact; “*To our daughters it is somehow difficult to teach [this older method of family planning] ... If they do that they think their husbands will go to other women.*”³⁶ A detailed table presenting the health situation along with demographic data in Angola is presented in Annex 5.

III.A.5. Consensus Building

Around 35 decision makers and program managers attended a two-day stakeholders meeting held in June 2003 in Luanda. The major objective of the meeting was for participants to share their knowledge and experience and to reach consensus regarding the current health situation across four dimensions: access, demand, quality, and sustainability of FP/RH systems. The attendees of the meeting, its objectives, and its agenda are presented in Annexes 6 and 7.

The following table provides a summary of the strengths and weaknesses of the current health situation in Angola as determined by the stakeholders during the meeting.

TABLE 2: STRATEGIC MAPPING OF THE FAMILY PLANNING PROGRAM: CONSENSUS ON THE EXISTING SITUATION—STAKEHOLDERS’ MEETING	
STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> ✓ Methods available at the national level ✓ Methods provided for free ✓ Family planning services in all provincial seats ✓ Family planning lectures available ✓ Technicians received specific training in family planning 	<ul style="list-style-type: none"> ✓ Deficient distribution of contraceptive methods to the provinces ✓ Vertical system for contraceptive distribution ✓ Rapid replacement and turnover of staff ✓ Long-term methods such as sterilization and irreversible family planning methods

³³ United Nations Population Fund (UNFPA). 2002. *The Trajectory of Life as Internally Displaced Persons in Angola*. Luanda, Angola: UNFPA.

³⁴ GOAL. 2003. *Family Planning Qualitative Survey Report*. Luena, Moxico, Angola: GOAL, p. 5.

³⁵ GOAL. 2003. *Family Planning Qualitative Survey Report*. Luena, Moxico, Angola: GOAL.

³⁶ GOAL. 2003. *Family Planning Qualitative Survey Report*. Luena, Moxico, Angola: GOAL, p. 5.

TABLE 2: STRATEGIC MAPPING OF THE FAMILY PLANNING PROGRAM: CONSENSUS ON THE EXISTING SITUATION—STAKEHOLDERS’ MEETING

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> ✓ Current strategic plan for reproductive health programs developed ✓ Intersectoral and multisectoral commitment and collaboration started (Social Communication, Youth and Sports, Women, and Education Ministries and the Directorate of Public Health) ✓ Permanent national supervision system ✓ Initiative for in-service training between doctors and nurses under way 	<ul style="list-style-type: none"> not offered ✓ Few NGOs involved in family planning program ✓ Little interaction among NGOs working in FP/RH

III.B. Phase One: Interviews of Focus Groups and Key Informants

The following table presents the focus groups, the individual interviews, and the health sites observed in each province during the period of 11 June to 1 July 2003. The site observations guide developed for the visits is provided in Annex 4. Annex 8 lists the organizations and the interviewees.

TABLE 3:	FOCUS GROUP DISCUSSIONS, INTERVIEWS, AND SITE OBSERVATION CONDUCTED ³⁷		
	PROVINCE		
FOCUS GROUP	LUANDA	BENGUELA	HUAMBO
Women	3 FGDs (Palanca, Viana, Ilha)	2 FGDs (women from marketplace)	2 FGDs
Men	3 FGDs	2 FGDs (urban and peri-urban)	1 FGD
Adolescents	3 FGDs (youth male and female)	4 FGDs (3 were mixed youth, male and female; one with young women from marketplace only)	4 FGDs (youth separated by sex; 2 rural, 2 urban)
Nurses	3 FGDs		1 FGD
Traditional Birth Attendants		2 FGDs	1 FGD
INTERVIEWS	LUANDA	BENGUELA	HUAMBO

³⁷ Note: OCHA = United Nations Office for the Coordination of Humanitarian Affairs, DSP = Direcção de Saúde Pública (Directorate of Public Health), PSI = Population Services International, CAOL = Coordination of Obstetric Supervision in Luanda.

TABLE 3:	FOCUS GROUP DISCUSSIONS, INTERVIEWS, AND SITE OBSERVATION CONDUCTED³⁷		
	PROVINCE		
FOCUS GROUP	LUANDA	BENGUELA	HUAMBO
	UNICEF, UNFPA, OCHA, WHO	Head of Provincial Public Health (DSP) [informal meeting]	UNICEF, OCHA, PSI
	Coordination of Obstetric Supervision in Luanda (CAOL)	2 FP/RH Health Center Supervisors	Head of Provincial Public Health (DSP)
	Archbishop and Rector of Catholic University	2 Maternity MDs/ Gynecologists	Archbishop
		Head of Dept. of Family and Women Promotion (Minas, Ministry of Social Affairs)	Technical Institute of Health
	Community Leader (Soba)		Community Leader (Soba)
			Leader of Traditional Birth Attendants
OBSERVATION	LUANDA	BENGUELA	HUAMBO
	3 Health Centers (Palanca, Viana, Ilha)	2 maternity hospitals (Lobito and Benguela)	
		3 Health Centers including FP (Baia Farta, Camunda; Sao Joao)	2 Health Centers (rural Bomba Alta and urban Mineira)
		1 Maternal and Infant Center (Benguela)	

III.B.1. Results of Focus Group Discussions

A total of 31 FGDs were conducted and the results analyzed. Only one FGD was eliminated because the women primarily spoke French and could not communicate well in Portuguese or in a local language. Six FGDs were not tape-recorded because the interviewers lacked the proper equipment. In these FGDs, two note-takers were employed to ensure all information was accurately recorded. The major findings for each profile (women, men, youth, nurses, and traditional birth attendants) provide extensive qualitative data for the Strategic Mapping process. The Annexes in the Portuguese version of this report give a full description of each of the FGDs, the individual interviews, and the completed health facilities observation guides.

Analysis of FGDs: The FGDs demonstrated that groups of similar profiles shared opinions on the importance of a variety of issues. For example, youth in both rural and urban areas want counseling and information on reproductive health and sexuality, and both groups felt they had inadequate information about family planning and limited access to services. This lack of

information and access to services was even more apparent in Huambo, where as of July 2003 there was still no youth-centered club or organization. The only differences were found between women running small businesses (market sellers, often single women) and married women without jobs outside the home; the perceived contraceptive needs of working women were greater than those of the jobless women, whose husbands want them to have many children.

Just as few differences were identified among the various focus group profiles, the team found few variations across regions. Respondents from all three provinces expressed the same confusion regarding contraceptive side effects and the negative impact of modern family planning methods. In general, the youth requested more information. However, the youth of Benguela, thanks to the Informed, Responsible and Organized Youth Organization (JIRO), have more exposure to family planning, reproductive health, and HIV/AIDS information than do the youth in Huambo, where JIRO is not yet active. Overall, the respondents from Luanda had more resources in terms of health facilities, equipment, and supplies and, therefore, more knowledge and exposure to contraceptive methods and services. In each area surveyed, women are quite dependent on men and express a fear of losing their partners if they do not have children.

The following table describes the perceived negative factors or obstacles and positive factors or determinants of family planning among the population interviewed and observed.

TABLE 4: PERCEIVED ACCESS, DEMAND, AND QUALITY OF FAMILY PLANNING BY THE POPULATION	
Major obstacles/negative factors of family planning	Main positive factors or determinants of family planning
<ul style="list-style-type: none"> ○ The desire to have large families after the war ○ Cultural norms that consider children as part of the wealth of the family ○ Men’s opposition to family planning ○ The contradictory and often negative messages of the church regarding modern contraception ○ The poor quality of (insufficient equipment, lack of counseling) and difficult access to FP/RH services in the health facilities (often due to monetary demand) ○ The misinformation, misunderstanding, and negative rumors about modern contraceptive methods among the population ○ Youths’ ignorance regarding family planning and their fear to talk about sexuality (STIs, HIV/AIDS, FP/RH) ○ General negative perception of family planning ○ Birth spacing very rarely associated with family planning 	<ul style="list-style-type: none"> ○ Recognition that having many children is a high financial burden (in direct opposition to traditional idea of many children as wealth) ○ Desire and responsibility to offer a better life to their children (especially education) ○ Birth spacing naturally practiced (2-3 years) ○ Many health centers equipped with family planning facilities, resources, and supplies ○ Women talk about family planning and some would like to practice it

The Strategic Mapping team analyzed the findings and summarized the perceived needs, understanding, and decision-making process for each group. Examples and quotes presented in this report reinforce the major points presented in this table.

Major Findings from FGDs with Men

Men who participated in the focus groups in all three provinces, especially in Luanda, demonstrated some knowledge of family planning and contraceptive methods. However, comments on family planning frequently reveal inaccurate knowledge regarding the use, effects, and benefits of family planning. The majority of men interviewed stated that issues related to family planning are “women’s matters” or “God’s will.” They distanced themselves from being a major part of the decision-making process. It is both interesting and important to understand and take note of the contradictory opinions voiced by males regarding family planning.

Despite the fact that men know the economic and health benefits of family planning, fears regarding infertility, promiscuity, and religion abound. The basic belief that large families are inherently good also makes it difficult for men to view limiting family size as positive. However, one respondent did mention the benefits of family planning in terms of improved sexual relations.

Photo 3. FGD With Men in Palanca Luanda



Photo : B. de Neeri

Quotes from Men’s Groups (translated from Portuguese):

“Family planning is quite important because it limits one from having a lot of children; after family planning, you can have normal [sexual] relations because the woman does not get pregnant...” (A man from Ilha, Luanda)

“I have heard that in practice this [family] planning prejudices women who cannot get pregnant anymore...” (A man from Ilha, Luanda)

“There are men who, when their wives think of using family planning, imagine that their wives are having sexual relations outside their family.” (A man from Viana, Luanda)

“...[Family planning] should be a common decision, but there are men who are the bosses and are quite dictators, and the women can only follow their wishes, or the relationship may end.” (A man from Viana, Luanda)

“...Our women do not like to use family planning because all that God gives us is what we have to keep.” (A man from Baixa, Huambo)

It is also crucial to note how the conflict that has gripped the country for decades has affected perceptions of family planning. In the face of the losses suffered during the conflict, some people have been prompted to have more children, despite the difficulties in raising them. War was sometimes mentioned as a reason for wanting large families even as the interviewees recognized economic difficulties as a barrier to having many children.

The majority of the men interviewed perceived birth spacing in two-year intervals as an acceptable practice, but did not generally have a comprehension of the health benefits of that spacing. Only a few men associated family planning with birth spacing because birth spacing is seen as a natural phenomenon. Similarly, men were not opposed to breast-feeding because it is considered a natural thing to do, but breast-feeding is also not often perceived as a family planning method.

Major Findings from FGDs with Women

All women interviewed during the FGDs in Luanda, Benguela, and Huambo agreed that men desire to have many children. Women felt that if they did not have children, the probability of the man having a child with another willing woman was significant. Additionally, women in

Photo 4. FGD with young women from Lobito



Photo : B. de Negri

these groups felt that men were opposed to family planning or were not supportive of women's decisions to use family planning. One woman said, *"For me, I want to use family planning; I talk with my husband and he does not respond; he just says: You are the one who knows to use*

(family planning) or not..." Finally, religion plays a role in women's family planning decision-making as well; the church puts forth the claim that children are decisions of God.

In some cases, women acknowledged that they had received family planning counseling and services covertly because of the fear that their partners would disapprove and even prevent them from seeking services. To cope with these situations, women used such discretionary measures as hiding the contraceptive method and leaving their family planning records with providers.

"...There are men who do not like it, do not accept family planning; I know that if I do not want to be pregnant, I can use it, hiding [from my husband]..." Woman from Viana, Luanda

The results showed that the women who worked in the markets were more aware of the benefits of family planning because they associate pregnancy and childbirth with a woman's inability to generate income. Their desire for more information and services on family planning also stemmed from a fear that their children would be street children.

"The economic factors determine [whether] to have more children or not; the fact is that for women who have a small business, they cannot have many children as they have a negative impact on the business and they would be street children..." A woman from the market at Camunda, Benguela

Overall, the women did not have many opinions regarding the quality of reproductive health services. Women's lack of empowerment and their cultural subordination to men do not allow them to raise their voices or criticize. The standard for quality seems minimal and poor quality is considered the norm. At some of the sites that were visited, the team observed a lack of sensitivity

among health providers ranging from indifference to disrespect and rudeness. The client–physician relationship consists of the doctor prescribing and advising on how to take medication, and instructions for a follow-up appointment without explanation of the client’s ailments or any physiological understanding on the client’s part.

“There are nurses, ...people who have a gift and others who are rude; they bring their problems from home.” A woman from the rural market, Chapanguela, Lobito, Benguela

Access to services is also a major concern because of the location of health facilities, cost of services, and the clients’ uncertainty about these fees and services. Lack of facilities in close proximity to communities is a major limiting factor, as most women live far from the health centers and cannot afford to pay for transportation. In some cases, transportation simply does not exist.

In addition to distance, the cost of health services is perceived as a barrier to clients. Communities are poor, and for many women and children, fee-for-service systems become prohibitive. The cost of using public health facilities that are subsidized by the government can ultimately be higher than the cost of private health services. In Angola, there are miscellaneous fees incorporated into the client visit, such as payments to doorkeepers, cleaners, and other non-essential staff. One woman shared her experience at a clinic in the FGD (see box below). Her example illustrates not only the unpredictability of the service or follow-up costs but also the understanding that the client expects to pay for quality services despite the changing fees.

“When you go for a medical appointment, they prepare a form for analysis. In order to get the analysis, you have to come with a new syringe, or you have to buy it there. As a patient, we have to help [pay] here and there; the person gives little cash, 20 Kwzs; plus the analysis, 80 Kwzs. From there, they give you a card. The doctor asks you to do a sonogram; you must pay for that sonogram. It all depends on the luck you get. Some pay 400 Kwzs, others pay US\$20.00, it all depends on your luck. These days, it is necessary to give something...” A woman from Luanda

Photo 5: Young woman breastfeeding, São João Health Center,



Natural family planning methods such as the calendar method and breastfeeding are used and accepted by women, even though they are not considered family planning methods.

Photo: B de Negri

Side effects of contraceptives have created a very negative perception of modern contraceptive methods. For example, Depo-Provera is associated with severe hemorrhagic bleeding and years of infertility.

“Family planning complicates things. For example, the pills and some injections cut the menstruation; sometimes they give you hemorrhage, and the IUD gives you infection. It starts from inside, grows, and the injury is so big inside...Nothing is good, the IUD or the injections, it is all the same...” Woman from Palanca, Luanda

Major Findings from FGDs with Youth

In general, the FGDs undertaken with youth did not provide as much information as those with adults, due in large part to their discomfort and lack of knowledge about FP/RH. This was particularly true in the rural areas, such as in Huambo where JIRO does not yet exist. Indeed, the findings reveal that JIRO has had a positive impact on the communities in which it organizes discussions on sexuality, HIV/AIDS, STIs, and family planning and offers contraceptive methods to the youth free of charge.

Photo 6. FGD with Youth – Palanca, Luanda



Photo : B. de Negri

Discomfort and silence were common while conducting FGDs with youth. The adolescents expressed the difficulty they have

in seeking counseling and basic information on HIV/AIDS, STIs, and FP.

An adolescent in Huambo said that family planning did not target youth: *“I never went to use family planning. We, the young girls, were told that we could not get family planning.”* Another teenager in Benguela said, *“I have never been interested in going to use family planning... It is not for me.”*

The youth, especially in rural areas of Huambo and Benguela, did not know what to do or with whom to talk about family planning. Some of them clearly expressed the difficulty they had in talking with their parents. A young woman from Luanda said to her boyfriend that if her father knew she was pregnant, he would kill her. In response, the boyfriend told her to abort. More often, friends or “the aunt” were mentioned as sources of information or advice.

When asked about modern contraceptive methods, condoms and the calendar method were the two methods most often mentioned. Discussion of other modern methods was accompanied by negative and confused statements. *“The injection often gives you hemorrhage; and in the case of the IUD, the person stays ‘disfigured,’ dry and dirty. That is why people use the calendar,”* said a young urban woman from Huambo.

Youth in the provinces expressed an interest in knowing

Photo 7. Youth at FGD in Huambo



Photo : B. de Negri

more about reproductive health, STIs, HIV/AIDS, and family planning. The adolescents prefer organized structures as resources for this type of information, support, and counseling. A few young respondents talked about using educational resources (see box below).

“...I wish to receive a seminar [on sexual and reproductive health issues] because the level of knowledge is so low here in the neighborhood.” An adolescent from Camunda, Benguela

“We need to have organized campaigns to help to solve the severe problems the young people are facing today in our country ...to teach us how to prevent these [sexually transmitted] diseases.” An adolescent from Camunda, Benguela

Photo 8. Adolescents from Lobito, Benguela

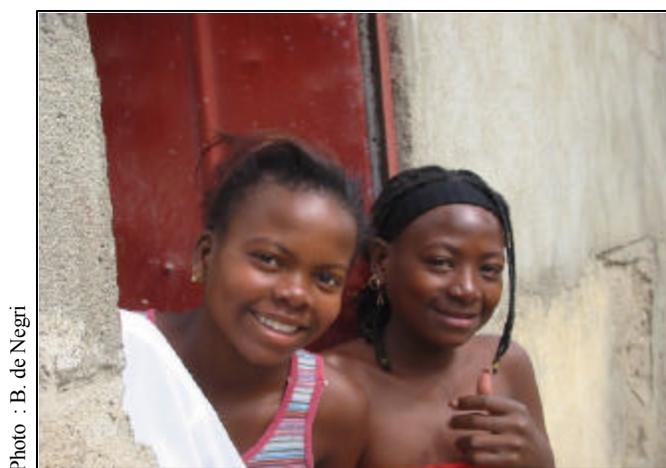


Photo : B. de Negri

Major Findings from FGDs with Nurses

Overall, nurses who participated in FGDs agreed that women sought health services primarily for prenatal care. One complaint was that women often seek help only when their health conditions become severe.

“... Women arrive when they are in severe condition, for example, with hemorrhage; there is little we can do... it is too late.” A nurse from Benguela

When asked about family planning services, nurses said that despite the fact that services are free, consent from husbands may not be forthcoming. The nurses considered resistance from males a major obstacle to women’s utilization of family planning services. Echoing the responses from the women’s FGDs in all three provinces, the nurses reinforced the idea that women fear losing their husbands or partners to other women if they use family planning. A husband’s consent is required by many health providers, as the nurses in the FGDs confirmed. The family planning nurse at the health center in Baia Farta said, *“We do not give the woman contraceptive methods if she does not come with her husband; both have to agree to take it.”*

Other major issues for nurses included a lack of proper equipment and an overwhelmed nursing staff, who are frequently required to do all the work in the facilities. The importance of maintaining a clinic was clear to the research team; while observing and visiting the health centers, the team noticed that the orderliness and cleanliness of the waiting room created a more conducive environment for women as they waited for services. The burden on nurses to keep their facilities clean is added to their already heavy workloads.

Photo 9. A well-organized, roofed waiting area, Palanca



Photo : B. de Negri

In Luanda, the most requested contraceptive method is Depo-Provera, and the second is condoms from JIRO. Nurses from Ilha (Luanda) stated that family planning is thoroughly explained to the patients and that they choose the method most suitable for their needs. Furthermore, the nurses said that they discuss family planning with pregnant women, especially during delivery and at postpartum visits.

In Palanca, Luanda, the nurses explained the benefits of conducting regular home visits and the appreciation of those they visited. These home visits, in addition to the presence of a physician in the health center, motivated women to seek services.

To improve family planning services, the nurses recommended the integration of family planning with other health services. A specific suggestion was to offer family planning to youth and

clearly illustrate the advantages of family planning and explain the side effects of different methods. Sensitization of males was another recommendation. One nurse commented, “*Men who think that their wives are ‘bandidas’³⁸, should be sensitized!*”

In the province of Huambo, a nurse mentioned that women were often interested in treating problems related to infertility because they wanted to have children. She continued by saying, “*Many of them [women] come in severe condition because they already took traditional medicine, and this put them at risk.*” Although this was the only mention of women seeking infertility treatment, women often expressed a fear of infertility as a result of contraceptive use was pervasive. The fact that women link contraceptive use with infertility, as well as the role of traditional medicine in women’s lives, should be taken into consideration. Finally, the nurses stressed the importance of preventive care and early identification of disease to lower mortality and morbidity.

Photo 10. Nurse at work, Camunda, Benguela



Photo : B. de Negri

³⁸ Literally meaning “bandit,” but used in this context to signify the idea that women who use family planning are engaging in sexual relations with multiple partners.

Major Findings from FGDs with Traditional Birth Attendants

Similar to nurses, traditional birth attendants (TBAs) regret that women often come to see them when it is too late to solve their problems. According to the TBAs, women do not come regularly during their pregnancy for monitoring and referral to the hospital, if needed, to avoid complications. TBAs say that women go to community leaders to complain about the TBAs and to blame them for poor health and the deaths of mothers and children.

TBAs were clearly aware of their need to know and understand more regarding pregnancy-related issues. They proposed that stronger linkages be established between TBAs and nurses from maternity wards and hospitals. Although one health center in Benguela (Baia Farta) had a strong relationship with the TBAs that included training, the situation for TBAs in Camenga was different. The health center there did not even know the number of TBAs serving in the community.

The TBAs who were interviewed said that family planning options were not discussed with women who came to them; it never occurred to many of the TBAs to offer or provide contraceptives. While visiting the Marie Stopes private maternal and child health (MCH)/family planning clinic in Luanda, the Strategic Mapping team was informed that it is against the law for TBAs to provide contraceptives.

Photo 11: TBAs at an FGD in Sao Joao, Benguela



Photo : B. de Negri

III.C.2. Major Findings from Semi-Structured Interviews

The team selected different profiles of leaders to conduct individual interviews in the three provinces. Key informants were identified based on their interest in FP/RH issues. Among them were religious leaders, community leaders, UN health officials, NGO representatives, provincial health providers or directors, and medical doctors from provincial maternity hospitals/hospitals.

The informants agreed that there are two major determinants (or external factors) that negatively impact family planning utilization: (1) the degree of poverty of the population, and (2) the lack of education, especially among women.

The head of the Department of Women and Family Affairs in the MOH in Benguela said that illiteracy prevents women from having access to resources, which makes them dependent upon men.

Photo 12. Community leaders at Lobito, Benguela



Photo : B. de Negri

Lack of resources also prevents women from making decisions regarding sexual and reproductive health. One UNFPA informant said, *“Women who suffer from ignorance do not know the benefits of family planning and are influenced by [negative] rumors.”*

The Catholic Church is certainly reticent regarding family planning in Angola.

However, the Archbishop in Luanda, who is also the Rector of the Catholic University in

Luanda, was quite receptive to a conversation with a representative of Advance Africa and talked openly about the reality of sexuality among youth. He acknowledged that the church plays a role in reproductive health, but the church’s structure is not an exclusive mechanism for information and awareness. In contrast, the church representative in Huambo demonstrated a high level of irritability and, apparently, the sermon he gave the Sunday after his conversation with an Advance Africa team member focused on opposition to family planning.

Numerous community leaders showed a high level of commitment to reproductive health, as evidenced by their involvement in organizing FGDs and the positive environment that they created for discussion and dialogue. On several occasions, the community leaders expressed the critical need to address FP/RH to youth who are *“so ignorant,”* as stated by a community leader of Lobito, Benguela.

III.C.3. Selected Site Visits for Observational Study

Site visits and observations were conducted at several health centers for the Strategic Mapping. The following table contains details on province and site.

TABLE 5: LIST OF THE HEALTH CENTERS AND MATERNITY HOSPITALS OBSERVED		
LUANDA	BENGUELA	HUAMBO
Health Center of Palanca	Health/Family Planning Center of Baia Farta	Mineira Health Center
Health Center of Viana	Maternity of Benguela	Health Center of Bomba Alta
Health Center of Ilha	Maternity of Lobito	
	Health/Family Planning Center of Sao Joao, Lobito	
	Health/Family Planning Center of Camenda	
	Maternal and Child Health/Family Planning Center	

Using the observation guide (see Annex 4), a systematic review of each site was conducted. Overall, the centers were found to be quite functional, despite operating with minimal equipment. Personnel was often available and in large numbers. Unfortunately, the team found that many health centers had no patients after 11:00 a.m.

Photo 13. Medical Staff at the Maternity Hospital, Baia Farta, Benguela



Photo : B. de Negri

Several of the centers the team visited had a maternity section with a few beds. However, in most health center maternity units, beds were empty or were occupied by mothers without their children. The explanation provided by staff was that the majority of these clients were maternity cases with serious complications, where the infant was stillborn or died during delivery.

Photo 14. Clinic in Benguela



Photo : B. de Negri

Many health centers that offer family planning have their own family planning consultation room with basic supplies. Generally, contraceptive methods are available and free of charge.³⁹ The majority of family planning facilities have their own tracking system, but the registration book that was presented to the team showed that the entries on attendance and services provided were not always accurate or updated.

Some information, education, and communication (IEC) materials were on display. Unfortunately, they were outdated, wordy, and not targeted to specific populations.

Photo 15. Family Planning Information Tracking



Photo : B. de Negri

Photo 16. Family Planning IEC



Photo : B. de Negri

³⁹ The Strategic Mapping team did not visit many health centers in Huambo in July 2003 due to lack of time and difficulty of travel within the province. However, in August, the team did visit 16 health centers in Huambo. The situation of the health centers is quite different in Huambo than in Benguela and Luanda. Huambo does not have family planning supplies available, and if family planning is offered in a health center, it is often not a priority, and therefore neglected by the personnel.

III.D. Summarized Results of the Strategic Mapping Exercise – The Maps

The following tables present the overall situation based on the results of the assessment phase of the Strategic Mapping exercise. The maps present the current FP/RH situation according to access, demand, quality, and sustainability.

A. Summary Analysis of Access to FP/RH Information and Services:

Actual provision of information and counseling services and products in the provincial health system

Minimum Package of FP/RH Information and Services											
Target Population	Local Health Clinics	Maternity in Health Centers	Municipal Maternity hospitals	Provincial Hospitals	NGO Clinics	Pharmacies	Community Groups or Associations	Schools	Other Sectors: Social, Youth, Agriculture	Media	Service Centers and Information
Female Youth	0/+	+	+	+	0	0	0	0	0	0	0
Women of Reproductive Age	0/+	+	+	+	0	0	0	0	0	0	0
Male Youth	0/+	+	+	+	0	0	0	0	0	0	0
Men of Reproductive Age	0/+	0/+	0/+	0/+	0	0	0	0	0	0	0
Country	0/+	0/+	0/+	0/+	0	0	0	0	0	0	0

Analysis: Multi-sectoral linkages of family planning with other types of activities are very limited. Clients find family planning services only at the provincial and maternal health centers. However, at local health centers, family planning counseling and services are available to a limited extent with some implementation for specific target groups. NGO clinics do not provide family planning services and are, therefore, a major gap in private sector family planning promotion. The behavior change communication (BCC) and IEC activities that are necessary to support family planning awareness and acceptance among the population are not documented. However, community mobilization through use of population networks that are engaged in different activities other than health are common and well accepted. The benefits of health services, including FP/RH services, are often not perceived by the community, so there is much work to be done in order for the community to be receptive to behavior change in terms of family planning.

B. Summary Analysis of Demand for FP/RH Information and Services:

Actual provision of information and counseling services and products in the provincial health system to stimulate demand

Services	Public Sector		Private Sector		Community Level	
	Provincial Hospitals	Local Hospitals and Health Centers	Private for-Profit Health Clinics	Private Not-for-Profit Health Clinics	Community Structures	Schools, Media, and Others
Information on Benefits of Birth Spacing	0/+	0/+	NA	NA	0	0
Information, Counseling on Methods	+	+	NA	NA	0	0
Information on the Correct Use of Methods	+	+	NA	NA	0	0
Provision of the Methods	+	+	NA	NA	0	0
Information on Collateral Effects of Methods	+	+	NA	NA	0	0
Counseling on Collateral Effects of Methods	+	+	NA	NA	0	0
Information on Return Visits and Follow-up	+	+	NA	NA	0	0
Information and Financial Accessibility	+	+	NA	NA	0	0

Analysis: Unfortunately, the Strategic Mapping team did not look at the private sector, except in one or two instances (Population Services International, Marie Stopes). As presented in the table, demand is at the public health sector level exclusively. Very little is taking place at the community level, such as through schools and the media.

B. Summary Analysis of Demand for FP/RH Information and Services: (cont.)

Actual provision of information and counseling services and products in the provincial health system to stimulate demand

Services	Potential Support		Support Structures		Others	
	Local NGOs	Voluntary Traditional Birth Attendants	Schools	Community Groups and Associations	Leaders	Intersectional Collaboration
Information on Benefits of Birth Spacing	0	0	0	0	0	0
Information, Counseling on Different Methods	0	0	0	0	0	0
Information on the Correct Use of Methods	0	0	0	0	0	0
Provide the Methods	0	0	0	0	0	0
Information on Collateral Effects of Methods	0	0	0	0	0	0
Counseling on Collateral Effects of Methods	0	0	0	0	0	0
Information on Return Visits and Follow-up	0	0	0	0	0	0
Information and Financial Accessibility	0	0	N/A	N/A	N/A	N/A

Analysis : This grid shows that FP/RH information, services, and counseling are not available or adequate according to the Strategic Mapping triangulation findings. Overall, it shows that the demand for provision of services and products is not satisfied.

**C. Summary Analysis of Quality in FP/RH Information and Services:
Correct use of quality norms, protocols, and standards in counseling services and products in the provincial health system**

Services Analyzed	Public Sector		Private Sector		Community Level	
	Provincial Hospitals	Local Hospitals and Health Centers	Private For-Profit Health Clinics	Private Not-For-Profit Health Clinics	Community Structures	Schools, Media and Others
Condoms	+	+	+	+	0	0
Injectables	+	0	0	0	0	0
Pills	+	0	0	0	0	0
IUDs	+	0	0	0	0	0
Norplant	+	0	0	0	0	0
Counseling	+	+	0	0	0	0
Diagnosis of STIs	+	0	0	0	0	0
Treatment of STIs	+	0	0	0	0	0
Counseling in FP/VCT	0 (4 in Luanda)	0	0	0	0	0
Counseling in FP/PMTCT	0 (1 in Luanda)	0	0	0	0	0

Note: IUD = intra-uterine device; VCT = voluntary counseling and testing for HIV/AIDS; PMTCT = prevention of mother-to-child transmission of HIV/AIDS.

Analysis : The same observations and conclusions can be drawn from the different sectors (public, private, and non-health) regarding the provision of optimal quality norms, protocols, and standards in counseling services and products within the provincial health system.

**D. Summary Analysis of Sustainability in FP/RH Activities:
Health sectors that support sustainability measures**

Services	Public Sector		Private Sector		Community Level	
	National Level	Provincial Level	Private For-Profit Health Clinics	Private Not-For-Profit Health Clinics	Community Structures	Schools, Media and others
Policy and Action Plan	+	0/+	0	0	0	0
Implementation Strategies	+	0/+	0	0	0	0
Norms, Protocols, and Standards	+	0/+	0	0	0	0
Strategies for Advocacy and Social Mobilization	+	0	0	0	0	0
Functional Contraceptive Logistics	0	0	0	0	0	0
Training Curriculum	0	0	0	0	0	0
Sustainable Financial Resources	0	0	0	0	0	0

Analysis: This grid demonstrates the reality that Angola has little in place to sustain health services for the population. Only at the policy and strategic levels is there any kind of activity.

IV. GROUP PLANNING

IV.A. Development

The key partners who were present at the stakeholders' June meeting returned to hear and discuss the findings of the assessment. The group was larger than in June, as some NGOs and UN members heard about the work and were interested in learning more.

At this stage of time, little detailed planning took place for two reasons: 1) because the head of the RH/MOH was out of the country and therefore no decisions could be made; and (2) because little family planning implementation was already in place in the country. However, along with Provincial Health Directors (DPS) from Benguela and Huambo, Advance Africa team members discussed plans for the implementation of a demonstration family planning program. The MOH had already made it clear that Advance Africa should not implement a demonstration family planning project in the capital; as stated by the head of the Reproductive Health Department, Dr. de Carvalho, "[In the capital, too many things [are] taking place in maternal-child health, and it would be difficult to measure the impact of [Advance Africa's] intervention." The team then discussed the level of efforts and the major components of the demonstration project in each of the two provinces visited during the assessment.

V. SELECTED STRATEGIES

Based on the findings gathered from the variety of sources tapped for the Strategic Mapping exercise, the design of future FP/RH activities will reflect the observed and articulated needs of the community. The proposed strategies build on existing possibilities identified in the community to make FP/RH services culturally appropriate and acceptable. The strategies for improving FP/RH service delivery relate to the following four components:

1. Improved access to and quality of health care resources
2. Integration of family planning into HIV/AIDS and MCH services
3. Community involvement
4. Partnerships and multi-sectoral collaboration

V.A. Improved Access to and Quality of Family Planning Services

To increase access to and quality of services, both health care providers and TBAs will be trained in family planning counseling and service provision. The current curriculum requires adaptation but will use existing training curricula as a base; norms and standards for quality of service delivery will be refined. The project will train current staff on the new and improved guidelines. These new protocols and standards will be used to ensure ongoing quality of service delivery. The training will emphasize counseling and interpersonal relationships, which is particularly important in Angola because of issues related to gender-based violence and exploitation due to both women's low status in society and factors associated with civil strife. This facet of the training will be especially relevant for adolescent girls.

Health services capacity will be improved through micro-planning at service delivery points, improved supervision and training, increased coordination, revised information system tools, and

adequate monitoring and evaluation. In collaboration with the community, the project will select TBAs for training to expand outreach. Management and administration at service delivery sites will be improved through strengthened monitoring and supervision systems. Logistics systems will be strengthened to eliminate stock-outs and increase contraceptive choice. The MOH, in collaboration with UNFPA, will ensure the availability of contraceptives over the life of the project.

V.B. Integration of Family Planning into HIV/AIDS and MCH Services

Planning will include integration of family planning into HIV/AIDS services as well as into prenatal and postnatal MCH services. This strategy will allow men and women to access family planning at other service delivery points. The project will examine management information systems in health centers and integrate family planning indicators. Angola-specific management information system activities will be adapted from Advance Africa's Performance Monitoring Plus framework, currently being implemented in Senegal. The integration of family planning will not be limited to services but will support other activities such as IEC and behavior change communication (BCC) implemented for immunization, safe motherhood, child survival, and HIV/AIDS prevention. In addition, this strategy will be supported by the training of volunteers using appropriate models such as community-based distribution, TBAs, activists, and community health workers.

V.C. Community Involvement

Throughout the project cycle, decentralization of family planning services to health committees and community structures will be an important consideration. Community acceptance of birth spacing as a legitimate FP method provides the basis for creating awareness of the benefits of family planning. IEC and BCC activities to inform and educate people on family planning will motivate community participation, which is crucial to designing sustainable family planning activities.

Among youth and males, specific strategies for IEC and BCC will be implemented to fill their needs and encourage their involvement in family planning programs. The project will create alliances with male groups, community leaders, and religious groups to sanction services and help communities seek services. Advocacy strategies targeted to leaders (community leaders, decision/policy makers, etc.) will stress the health and non-health benefits of birth spacing.

V.D. Partnerships and Multi-Sectoral Collaboration

Dialogue initiated during the Strategic Mapping exercise will continue among the major stakeholders, in particular NGOs and other donors, who will be able to support and leverage these activities. Among the partners will be the government; MOH/Division of FP/RH; UNFPA, WHO, and other UN agencies; the MSH project in Angola; and other international NGOs and agencies (IMC, CCF, Save the Children, Care International, etc.). The project will examine other sectors to determine whether they can also support FP/RH interventions, particularly for IEC and family planning integration with their activities. Community-based activities such as microenterprise, education, literacy, and youth-focused groups will be explored as possible

mechanisms for integration. A major issue identified was the lack of women's decision making regarding family planning service utilization. Part of the problem lies in cultural constraints, but the attitudes and behaviors of health care providers will be addressed through gender sensitivity training as it relates to serving women with different life situations.

At the end of the Strategic Mapping exercise, the Advance Africa team, along with the local research team, presented to stakeholders the preliminary findings and selected strategies in response to identified needs and gaps, as well as existing opportunities and strengths. The objective, agenda, and list of the participants at this meeting are presented in Annexes 9 and 10.

VI. CONCLUSION AND RECOMMENDATIONS

The Strategic Mapping conducted in Angola provides a first-level analysis, identifying opportunities, obstacles, and constraints that face the country as it moves forward with its National Reproductive Health Strategy. While there are many challenges, the potential exists to create an environment for an effective service delivery system for quality family planning. The assessment takes into account diverse perspectives from multiple levels and sources of information. The analysis was enriched by the stakeholders, who actively participated in the Strategic Mapping exercise; the community members, who openly communicated their concerns and perspectives; and the health providers, who are the people ultimately responsible for providing the quality services that men and women in Angola deserve.

A major achievement of this process has been the consensus achieved regarding family planning as a priority intervention to reach reproductive health goals. A variety of strategies at different levels have been identified to accomplish these objectives. Stakeholder involvement in the process has created partnership and ownership of the proposed plan of action and is supported by the Angolan government and stakeholders. Aspects at the community, health service delivery, and policy levels indicate the need to implement simultaneous activities to provide a coordinated program.

A major long-term outcome of this process will be the increased utilization of quality family planning services. At the policy level, coordination among different sectors and the integration of multiple services, such as those for safe motherhood, child survival, and HIV/AIDS, must be encouraged. At the service delivery level, both the site visits and the client focus group discussions indicated that services need to be improved and standards of quality must be met. Women who go to health centers seeking family planning services should encounter and receive information and services from trained, highly skilled providers who are supported by efficient logistics systems and adequate supplies.

IEC and BCC activities must be strengthened at the community level to promote appropriate, culturally accepted reproductive health concepts, such as birth spacing, in order to create demand for family planning. Moreover, health providers should be sensitized to provide services to clients in a culturally and gender-sensitive manner. Today, 29% of households in Angola are headed by women, and individual choice to limit or space children must be promoted. On the other hand, recognizing male power over decision making requires specific interventions that target male involvement in supporting women's family planning decisions. Even though interventions must reverse negative perceptions of family planning, success will be based on partnerships created with community leaders, religious leaders, and other groups.

Next Steps

Advance Africa will begin implementation in the province of Huambo in 13 health centers and their respective communities. A detailed workplan for the province of Huambo is being developed, with a focus on the need to improve the quality of health services and to respond to low family planning demand and access.

ANNEXES

ANNEX 1

Schedule for Reproductive Health/Family Planning/Birth Spacing Participatory Assessment and Workplan in Angola, June 1 to July 13, 2003

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
June 1 AA Technical Advisers' arrival	June 2 Morning: Meet with USAID and Dra. Adelaide Carvalho; preparation for presentation	June 3 Stakeholders/ decision makers meeting: presentations by gov't and NGOs	June 4 Stakeholders/ decision makers meeting: AA presentation and group working sessions	June 5 Meeting w/ MOH, USAID; individual interviews with decision makers	June 6 Meeting w/ MOH, USAID; individual interviews with decision makers	June 7 Work half day with team
June 8 Rest (arrival of key people from the regions)	June 9 Preparation for Luanda assessment	June 10 Field work in Luanda ("pre-test" of tools)	June 11 Field work in Luanda (training if necessary)	June 12 Data collection in Luanda thru FGDs, interviews, observations	June 13 Data collection in Luanda thru FGDs, interviews, observations	June 14 Data collection in Luanda thru FGDs, interviews, observations
June 15 Rest	June 16 Analysis of AA tools collected	June 17 Analysis of AA tools collected	June 18 Draft Luanda workplan	June 19 Draft Luanda workplan	June 20 Revision of the tools for the regions	June 21 Departure for the regions (sub-teams)
June 22 Rest (one sub-team in Huambo, the other in Benguela)	June 23 Preparation for assessments of Huambo and Benguela	June 24 Adaptation of the tools; preparation for data collection	June 25 Field work: data collection, FGDs, interviews, observations	June 26 Field work: data collection, FGDs, interviews, observations	June 27 Pre-analysis of data collected	June 28 Pre-analysis of data collected; draft regional workplans
June 29 Rest	June 30 Regional workplan development	July 1 Regional workplan development	July 2 Travel back to Luanda	July 3 Finalization of regional workplans and presentation to the team	July 4 Development of National Plan of Action from regional workplans with other organizations	July 5 Development of National Plan of Action from regional workplans with other organizations
July 6 Rest (arrival of AA Director Dr. Issakha Diallo)	July 7 Preparation for presentation of regional workplans and National Plan of Action	July 8 Preparation for presentation of regional workplans and National Plan of Action	July 9 Stakeholders/ decision makers meeting: presentation of National Plan of Action and regional workplans	July 10 Debriefing notes to MOH, USAID	July 11 Debriefing notes to MOH, USAID	July 12 AA Technical Advisers' departure July 13 AA Technical Advisers' departure

Note: AA = Advance Africa; USAID = U.S. Agency for International Development; gov't = government; NGO = nongovernmental organization; MOH = Ministry of Health; FGD = focus group discussion

Guides for Focus Group Discussions, June 9, 2003, Luanda
(Note: These were adapted while in the provinces)

Annex 2A: Guide for Men's Focus Group Discussions

O QUE ESTÁ POR DETRÁS DA DIMINUIÇÃO DA COBERTURA DO PF?

HOMENS

- 1. Quantos filhos gostariam de ter? Por quê?**
 - Educação
 - Saúde
 - Valor económico
 - Ajuda a família
 - Cuida
- 2. De quanto em quanto tempo a mulher deve engravidar?**
 - Razões
 - O que acontece se a mulher tiver muitos filhos seguidos?
- 3. O que vocês fazem para não terem filhos muito seguidos?**
 - Razões, motivos
- 4. [O que é para vocês o PF?] (se alguém falar em PF)**
 - Isso é coisa de mulher ...
- 5. Quem tomou a decisão?**
 - Porque resolveram assim? Como foi?
- 6. Onde conseguiram informação e orientação sobre PF?**
 - Se falarem em Centro de Saúde – Acompanharam as vossas mulheres a esses serviços?
 - O que acharam desses serviços?
- 7. Que métodos vocês utilizam para não engravidar?**
 - Que acham desses métodos?

Annex 2B: Guide for Women's Focus Group Discussions

O QUE ESTÁ POR DETRÁS DA DIMINUIÇÃO DA COBERTURA DO PF?

MULHERES

- 1. Quais são os problemas de saúde que afectam as mulheres deste bairro?**
 - Malária
 - Gravidez
 - Anemia

2. **De quanto em quanto tempo a mulher deve engravidar?**
 - Razões
 - Saúde da mulher
 - Número de filhos desejados
3. **O que vocês fazem para não terem filhos muito seguidos?**
 - Razões, motivos
 - PF
 - O que é para vocês fazer PF?
 - Onde procuram?
 - Como chegam lá?
 - Quanto tempo levam para chegar?
 - O que acham dos serviços?
 - Quanto custa?
4. **O que é para vocês fazer PF?**
5. **Quem tomou a decisão?**
6. **Onde conseguiram informação e orientação sobre PF?**
 - Serviços
 - Qualidade; Como melhorá-los?
 - Acesso – Custo
 - Disponibilidade de métodos
 - Aconselhamento
 - Barreiras/Tabus
7. **Que métodos vcs utilizam para não engravidar?**
 - Que acham dessem métodos?
 - Onde arranjam desses métodos?

Annex 2C: Guide for Youth Focus Group Discussions

O QUE ESTÁ POR DETRÁS DA DIMINUIÇÃO DA COBERTURA DO PF?

JOVENS

1. **Como ocupam os tempos livres?**
 - Namorar
2. **Como namoram os jovens? / O que é para vocês namorar?**
 - Fazem sexo
3. **Quais são as consequências de fazer sexo durante o namoro?**
 - Gravidez (indesejada)
4. **Onde é que vocês podem receber orientação ou conselhos para evitar a gravidez não desejada?**
 - Serviços
 - Problemas que encontram nesses serviços
5. **Que tipo de serviços procuram no Centro de Saúde?**
 - Planeamento Familiar
 - Conhecem os métodos
 - Quais usam mais?
6. **Se fosses Ministro da Saúde, como gostarias que fossem esses serviços?**

Annex 2D: Guide for Nurses' Focus Group Discussions

O QUE ESTÁ POR DETRÁS DA DIMINUIÇÃO DA COBERTURA DO PF?

ENFERMEIRAS

1. Problemas de saúde das mulheres nesta comunidade
2. Serviços que mais procuram? E que mais?
3. O que acham dos serviços de PF oferecidos na vossa unidade
 - Qualidade / Atendimento / Privacidade / Confidencialidade
 - Quais os métodos oferecidos?
 - Estão sempre disponíveis?
4. Como é o seu dia, quando tem consultas de PF?
5. Problemas que as mulheres mais apresentam nas consultas de PF
6. Que soluções têm dado para os problemas encontrados?
7. Se fosse Ministra da Saúde, e tivesse que abrir um serviço de PF, como é que seria?

Annex 2E: Guide for Traditional Birth Attendants Focus Group Discussions

O QUE ESTÁ POR DETRÁS DA DIMINUIÇÃO DA COBERTURA DO PF?

PARTEIRAS TRADICIONAIS

1. Pode por favor, queridas colegas falem-nos de vosso papel na comunidade.
2. Como é o estado geral das crianças nesta comunidade?
3. Na sua opinião como a comunidade de responde aos problemas de saúde.
4. Qual é a sua opinião especificamente em relação a saúde das mulheres (frequência das gravidezes, PF)?
5. Onde é que as mulheres vão procurar aconselhamento sobre PF?
6. Que solução tem dado para os problemas encontrados?
7. Qual é a relação das PTs com o Centro da Saúde?
8. Se fosses a líder das PTs na comunidade que condições gostaria que houvesse para desenvolver o seu trabalho?

Advance Africa Strategic Mapping Team – Participants

1. Avelina Magalhães dos Santos	Provincial Supervisor for the Family Planning Program, DSP Benguela
2. Domingos Jerônimo	Juvenile Leader, CAJ/JIRO
3. Eliseu Mateus	Juvenile Counselor, CAJ/JIRO
4. Elvira Joana Sauimbe	Responsible for the Provincial Family Planning Program, MOH, DSP Benguela
5. Eva Napolo Guilherme Castro	Nurse, CARE – Kuito, Bié
5. Júlia Grave	UNFPA DNSP
6. Maria Antonia Nogueira	Head of the Maternity Health Center Palanca (nurse midwife)
7. Maria de Lourdes Junça	IMC/MSH
8. Maria do Carmo C. da Cruz	National Supervisor of the Traditional Birth Attendants, DNSP
9. Maria Gabriela Xavier	Supervisor, Trainer, Responsible for Statistics, DNSP
10. Maria Josefa Dombolo	Trainer, CCF
11. Rosalina Catanha	Supervisor of the Reproductive Health Program, DSP Huambo
12. Teresa Joaquina	MCH nurse, CCF Benguela
13. Zipporah Wanjohi	Maternal and Child Health Adviser, USAID/Angola

Observation Guide – Walk-Through Tour Health Centers
STRATEGIC MAPPING – June-July 2003

SITE:

DATE:

CONDUCTED BY:

Questions	Yes	No	Comments
What are the hours of operation during the week?			
What are the hours of operation during the weekend?			
Does the center have a maternity?			
Does the center have a delivery room?			
How many beds for birth are there?			
Is there a MD coming to the Maternity ?			
How many nurses are on duty?			
Are there nurses for FP/RH?			

Does the facility have...?

Areas/Rooms	Yes	No	Comments
Waiting area			
FP/RH room			
Procedure rooms			
Laboratory area			
Pharmacy			
Maternity area			
Emergency room			
Was the overall state of facilities good?			

Is the following equipment available in the facility?

	Yes	No	Comments
Examination table			
Instruments table/tray			
Stethoscope			
Sonography equipment			
Blood collection equipment			
Antiseptics			
Sterile gloves			
Autoclave			
Boiler			
Syringes/needles			
Stool			
Desk			
Cabinets			
Bed linen			
Screens			
Curtains			
Separated laundry			

Client's Dimension: Ask the administrator or any health provider the following:

Questions	Yes	No	Comments
Is there any cost to be attended (specify)?			
Does the client pay per service received?			
Does the client receive orientation/education talks?			
Does the facility have any IEC materials (posters, TV, books, pamphlets)?			
Does the facility offer any FP/RH counseling?			

Record/Logbook Checklist: Ask the administrator to show you the registry books from the last months and if possible check for the following:

Questions	Yes	No	Comments
PHARMACY			
How are medications recorded?			
Are types of contraceptive methods recorded?			
FAMILY PLANNING FACILITY (if applicable)			
Does it have a record system?			
Who conducts FP IEC counseling?			
Are there any IEC materials available?			
DELIVERY ROOM			
How many deliveries were conducted at the facility in the last month?			
Deliveries			
Abortions			
CAUSES OF MORTALITY AT MATERNITY			
Does it have vaccination record cards available for clients?			
Does the room have a cold chain system?			
LABORATORY			
Does the lab have a record system? If so, for what? (Specify)			

Data on Demographic and Health Situation in Angola

FACTOR	2000 (est.)	1995-2000 (est.)	2005 (medium variance)	2000-2005 (medium variance)
Population (thousands) ⁽¹⁾				
Total	13,134 ⁽¹⁾		15,252	
Sex ratio (males per 100 females) ⁽¹⁾	97.9 ⁽¹⁾		98.3	
Age Distribution ⁽¹⁾				
Percentage aged 0-4	19.7		20.1	
Percentage aged 5-14	28.4		28.5	
Percentage aged 15-24	19.0		19.3	
Percentage aged 60 and over	4.5		4.3	
Percentage of women aged 15-49	42.7		42.7	
Median age (years) ⁽¹⁾	15.9		15.7	
Population growth rate (percentage) ⁽¹⁾		2.94		2.99
Maternal/Child Health				
Infant mortality rate (per 1,000 births) ⁽¹⁾		126		118
Mortality under age 5 (per 1,000 births) ⁽¹⁾				201
Maternal mortality ratio (per 100,000 births) ⁽²⁾	1,800			
Home births (percentage) ⁽²⁾	80			
Life Expectancy at Birth (years) ⁽¹⁾				
Both sexes combined		44.6		45.8
Male		43.3		44.5
Female		46.0		47.1
Family Planning				
Total fertility (per woman) ⁽¹⁾		7.20		7.20
Contraceptive prevalence rate ⁽²⁾	1.8			
Women practicing contraception (percentage) ⁽³⁾	8.1			
Women using modern methods of contraception (percentage) ⁽³⁾	3.5			
Women who do not want to have children (percentage) ⁽³⁾	22.7			

Social/Economic				
People living in poverty (percentage) ⁽⁴⁾ (1995)	61			
Adult literacy rate (% age 15 and above able to read a letter or newspaper) ⁽⁶⁾	67			
Female literacy rate (% of women 15 and above able to read a letter or newspaper) ⁽⁶⁾	54			
Male literacy rate (% of men 15 and above able to read a letter or newspaper) ⁽⁶⁾	82			
Households headed by women (percentage) ⁽⁶⁾	27			

Sources: (1) United Nations Population Division. *World Population Prospects: The 2000 Revision—Volume I: Comprehensive Tables*, p. 110; (2) Ministry of Health, National Directorate of Public Health, National Action Plan for FP/RH; (3) Instituto Nacional de Estatística (INE) and United Nations Childrens Fund (UNICEF). Multiple Indicator Cluster Survey, Angola. 1996; (4) Ministry of Health, National Office of Public Health, Strategic Plan for the National Program in the Fight Against AIDS, 1999-2002; (5) United Nations Development Programme . Human Development Reports, Angola, 2002; (6) UNICEF . Multiple Indicator Cluster Survey, Angola, 2001 .

**List of Participants at the First Stakeholders Meeting (Incomplete)
3-4 June 2003, Luanda**

Name	Organization
1. Avelina Magalhães Santos	DSP Benguela
2. Maria Antónia Nogueira	MOH/DSPL
3. Rosalina Catanha	DSP Huambo
4. Maria Gabriela Xavier	DNSP
5. Maria de Lourdes Junça	IMC MSH
6. Susan Shulman	PSI
7. Maria Roble	Columbia University/IMC
8. Fernando Vicente	IMC Huambo
9. Júlia Grave	UNFPA DNSP
10. Jaakko Yrjo-Koskinen	INDEVEL consultant
11. Vita Vemba	DSPL Luanda
12. Zipporah Wanjohi	USAID
13. Adelaide de Carvalho	Director, DNSP
14. Silvério dos Santos	CAJ/JIRO
15. Miguel Madeira	CAJ/JIRO
16. Nohra Villamil	IMC Huambo
17. Jaime Benavente	MSH
18. Elias Finde	Director, DSP Huambo
19. Júlio Leite	UNFPA
20. Maria José Queiros	DNSP, Office of Health Promotion
21. Mary Daly	CCF
22. Bérengère de Negri	Advance Africa
23. Susan Veras	Advance Africa
And more...	

Objectives and Agenda of the Stakeholders Meeting

Objectives:

By the end of the first stakeholders meeting, the participants will have:

- 1) Presented the FP/RH situation in Angola
- 2) Identified priorities for the FP/RH program
- 3) Arrived at a consensus on the gaps and weaknesses of the FP/RH program in Angola
- 4) Provided guidance for the field assessment activities
- 5) Become fully committed to the process and results of the participatory Strategic Mapping approach

Agenda

JUNE 3, 2003	Content	Responsible
9:00 am	Welcome remarks Goal	Ministry of Health/USAID
9:30 am	Ice-breaker Presentation of the participants Review of the objectives of the two-day meeting	Advance Africa/MSH
10:00 am	Introduction: Importance of a Consensus Building Process to Agree on an FP/RH National Program	Advance Africa Team
10:45 am	Coffee break	
11:15 am	Presentation by NGOs and UN organizations involved in FP/RH research and/or projects Up-to-date situation – Our reality today	MOH/DNSP CAJ/JIRO
12:30 pm	LUNCH	
1:30 pm	Presentation by NGOs and UN organizations (continued)	IMC
3: 30 pm	Coffee break	
4:00 pm	Presentation by NGOs and UN organizations (continued) Discussion and questions/answers	PSI UNFPA
5:30 pm	End of first day	

Agenda of the Stakeholders Meeting (second day)

JUNE 4, 2003	Content	Responsible
9:00 am	Advance Africa presentation	Advance Africa
9:30 am	Small group discussion on current program situation and performance in terms of access, demand, quality, and sustainability Agreement on the situation – Identification of gaps	All
10:45 am	Coffee break	
11:15 am	Continuation of small group discussion	All
12:30 am	Lunch	
1:30 pm	In plenary: Presentation of small group work Discussion: Consensus on strengths and weaknesses Divergence in opinion Needs for further assessment Main areas of agreement in terms of gaps and opportunities	All
3:30 pm	Coffee break	
4:00 pm	Same group work Exchange knowledge/experience of local “best practices” Agreeing on the “ideal situation” (realistic) with respect to key dimensions of service delivery Group presentation of the group work Discussion	Exercise facilitated by Advance Africa team
5:30 pm	Closing	

Name, Organization, and Function of the Key Informant Interviews

PROVINCE		
Luanda	Benguela	Huambo
Oscar Castillo, Coordinator Health and Nutrition Sector, UNICEF	Maternity Hospital of Lobito – MD Gynecologist	N’doza K. Luwawa, Resident Project Officer, UNICEF
Dom Damiao A. Franklin, Archbishop of Luanda and Rector of the Catholic University of Angola	Maternity Hospital of Benguela – MD Gynecologist	Dom Francisco Viti, Archbishop, Huambo
Isabel Massocolo Neves, Supervisor of RH Activities, Coordination of Obstetric Supervision in Luanda (CAOL)	Director of Department of the Family and Social Promotion, Ministry of the Family and Social Promotion	Elias Findi, Director, Provincial Directorate of Health (DSP)
Paulo A. Campos, Coordinator, CAOL	Avelina Magalhães dos Santos, Provincial Supervisor of FP Health Clinics	Maria Tereza Samanjata, Director, Technical Institute of Health
Julio Leite, Acting Director Antonica Hembe, UNFPA	Vanda Lucília da Silva, Pascoal Provincial Supervisor of MCH Program	Clementino Pedro, Sabá (Traditional Community Leader), Kapango
Paula Carosi, Senior Resident Officer, UN Office for the Coordination of Humanitarian Affairs (OCHA)		Azenildo Martinho, Coordinator PSI Huambo
		Fernando Arroyo, Resident Officer, OCHA
		Rebeca Benguela, Leader, Traditional Birth Attendants

List of Participants at Final Stakeholders Meeting

Name	Organization
1. Kela di Lumbenba	MSF/Bélgica
2. Elias Finde	Director of Directorate of Public Health (DSP) Huambo
3. Vita Vemba	Directorate of Public Health Luanda (DSPL)
4. Maria de Lourdes Junça	IMC MSH
5. Josephine Ngonyani	IMC Luanda
6. Nohra Villamil Torres	IMC Huambo
7. Elsa Ambriz	Head of the Department of Reproductive Health, National Directorate of Public Health (DNSP)
8. Júlia Grave	UNFPA DNSP
9. Cathy Bowes	USAID
10. Gilberto Ribeiro	USAID
11. Maria Conceição Tchivale	Marie Stopes
12. Maria Isabel Massocolo Neves	CAOL (Coordination of Obstetric Supervision in Luanda) – DSPL
13. Isabel Lemos Gomes	DNSP/Department of Women
14. Maria de Lourdes Melo	DNSP Reproductive Health
15. Maria do Carmo C. de Cruz	DNSP
16. Hironcina Cucubica	MSH/Child Survival
17. Eliseu Mateus	CAJ/JIRO (Youth)
18. Domingos Jerónimo	CAJ/JIRO (Youth)
19. Maria Josefa Dombolo	CCF
20. Victor Lara	UNICEF
21. Aida Menezes	DNSP/Child and Adolescent Health Department
22. Maria Isilda Neves	DSPL/Child and Adolescent Health Department – Luanda
23. Maria Antónia Nogueira	MOH/DSPL-Luanda
24. Eva Napolo G. Castro	CARE/Kuito
25. Maria Inês Leopoldo	MOH/Benguela
26. Ana Maria	Rádio
27. Hortênsia Trindade	MOH
28. Samson Ngonyanyi	Director, Africare
29. Susan Shulman	Director, PSI
30. Maria da Conceição	Oxfam Luanda
31. Lucas dos Santos	Oxfam Luanda
32. Maria José Queiroz	DNSP Office of Health Promotion
33. Verónica Tchivela	FESA Luanda
34. Basílio Cassoma	Director of National Department for Health Policy and Planning, MOH

35. Zipporah Wanjohi	Maternal and Child Health Adviser, USAID
36. Júlio Leite	Acting Director, UNFPA
37. José Ribeiro	UNFPA
38. Issakha Diallo	Director, Advance Africa
39. Bérengère de Negri	Advance Africa
40. Susan Veras	Advance Africa
41. Eduarda do Amaral Gourgel	Advance Africa

**Final Stakeholders Meeting
Presentation of the Strategic Mapping Results, Luanda, Angola
July 9, 2003**

OBJECTIVES

1. Presentation of the results of Advance Africa's Strategic Mapping
2. Presentation of the Action Plan
3. Consensus by participants on key points of results and Action Plan

AGENDA

9:30 Arrival of Participants

10:00 Opening Remarks

Elsa Ambriz, Head of the Department of Reproductive Health,
National Directorate of Public Health (DNSP)

Cathy Bowes, Director of Projects, USAID/Angola

10:30 Presentation of the Strategic Mapping Results by Advance Africa Team

11:30 Presentation of the Action Plan by Advance Africa Team

12:00 Debate/Questions of Key Points

12:30 Certificates Presented to the Research Team

12:30 Closing Remarks

12:45 Lunch

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