

Development Workshop

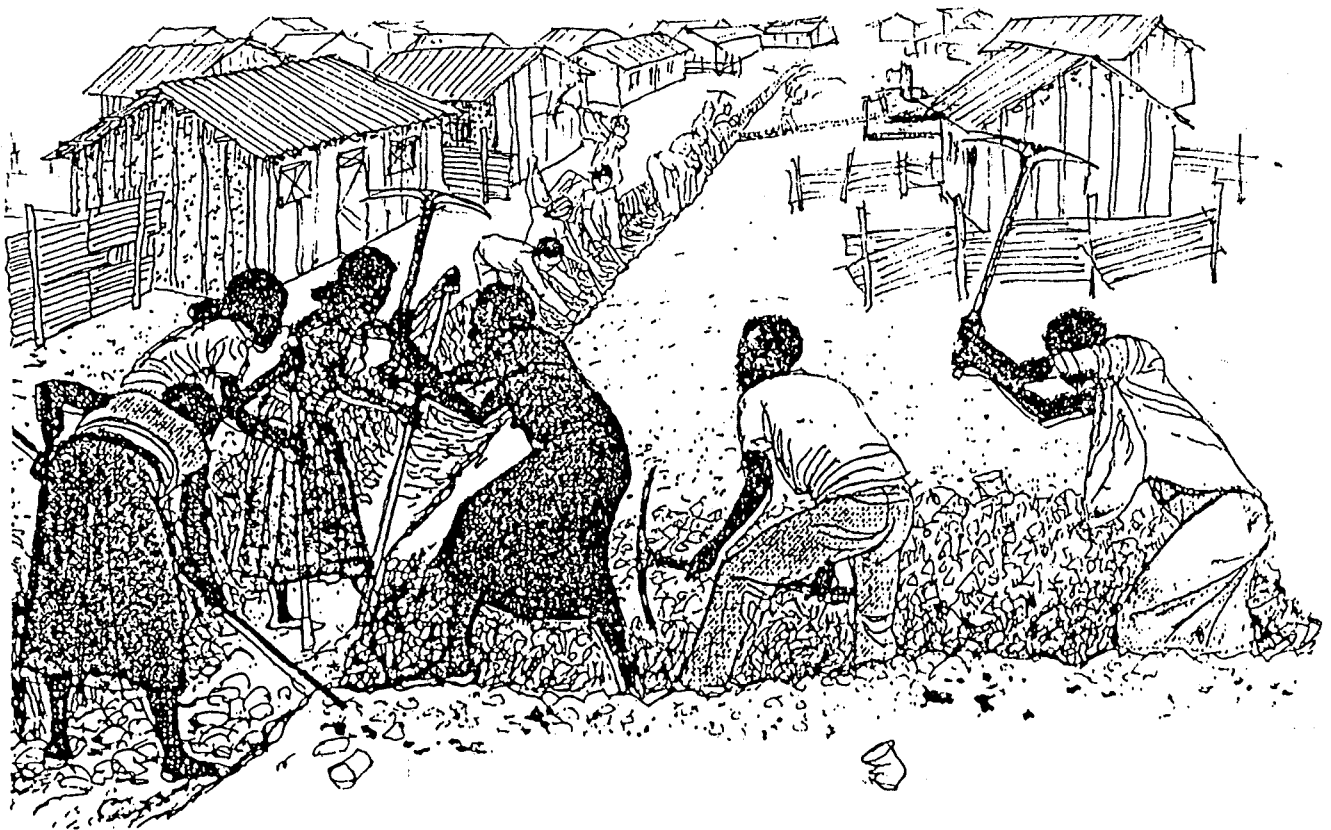
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SAMBIZANGA

COMMUNITY SANITATION AND UPGRADING PROJECT

Project Proposal



By

DEVELOPMENT WORKSHOP

Luanda - January 1992

Development Workshop

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To:

UNICEF Luanda

By:

DEVELOPMENT WORKSHOP

Luanda 1992

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GLOSSARY

DW	Development Workshop
UNICEF	United Nations Children's Fund
ASDI	Swedish International Development Agency
Musseque	Informal Peri-Urban Settlement
NGO	Non-Governmental Organization
CBO	Community Based Organization
GARM	Government Urban Upgrading Office
LHBNS	Luanda Household Budget and Nutrition Survey
MOH	Ministry of Health
ELISAL	Luanda Provincial Sanitation Company
EPAL	Luanda Provincial Water Company
DNA	National Water Department
PHC	Primary Health Care
HC	Health Centre
ENTRACO	German Contracting Company
AALSIDA	Angolan Association for the Fight Against AIDS

1.0 SUMMARY OF PROJECT

The Development Workshop (DW) is a human settlements NGO working in Angola since 1980 on projects of urban upgrading, rural resettlement and self-help construction. DW has collaborated with local government, NGO's and international organisations in their Angolan programme.

Development Workshop has been involved since 1986 in a series of urban development initiatives aimed at upgrading physical and environmental conditions and services for populations living in Luanda's "Musseques" or informal settlements.

Luanda continues to expand rapidly in area and density (calculated at between 8-15% annual growth). About three quarters of Luanda's 2,000,000 people live in the peri-urban Musseques. The Musseque communities have no infrastructure, and recognisable public services function minimally only in the areas of health and education. These existing services, however, have desintegrated through a combination of neglect, lack of maintenance policies and lack of appropriate expertise. The Angolan Government still lacks a coherent urban development policy which takes into account the reality of the Musseques where the majority of the population live. In fact new government policies of Structural Adjustment will, in the short term, exacerbate problems of Musseque families' household economies and access to services.

Community structures are still generally weak in the Musseques, but the recent political liberalization and publication of the Law of Freedom of Association has lead to a flowering of national Non-Governmental Organizations (NGO's) and local level Community Based Organizations (CBO's).

The present Project is part of DW's ongoing Musseque upgrading work which began in 1986 with an emergency study on the problems of basic urban sanitation and lead to a series of bairro improvement initiatives in Sambizanga Municipality. Development Workshop has recently undertaken a major programme evaluation and redefinition of objectives within the context of the community's own stated priorities and with reference to the increasing possibilities for community action arising from the current political reforms. The following document includes a detailed problem analysis as of early 1992, a consequent review of the working assumptions, an indication of a new direction and definition of new objectives. The document outlines the project plan for the period 1992-1995.

The document proposes to UNICEF and other international donors, support for a joint NGO / CBO initiative to improve access to basic water and sanitation services in a Musseque community of about 75,000 people. The project has adopted a three part strategy, and proposes parallel action in the following areas:

- training
- sanitation and upgrading
- community development

2.0 PROJECT BACKGROUND

2.1 Project Definition

The focus of this project is Ngola Kiluange, a urban community in Sambizanga Municipality, selected for its similarity to other Musseques in Luanda. The project area (bairro) embodies some characteristics of the old urban musseques as well as those of the rapidly growing musseques on the periphery of the city. The project aims to support this community through the process of acquiring access to water supply and improving basic sanitation services in their area. Through this process the project aims to develop the community's self awareness and their capacity to negotiate with political structures and the service providers in order to maintain and improve access to these services.

2.2 Project Location: and geography

Ngola Kiluange is 8 km from the centre of Luanda on the main road north of the city. Before independence the area was primarily an industrial zone with a low density population. Currently population density is high with no developed infrastructure. The major industries in the area, such as the refinery, make independent arrangements for their water and electricity needs.

2.3 Justification

The UNICEF commissioned Luanda Household Budget and Nutrition Survey, 1991 (LHBNS) suggests that the poor public health environment in which most Luandans live is a more important determinant of general health status than either levels of income or the quality and accessibility of formal health services. Their specific policy recommendations in the health sector are that attention should focus on public health rather than medical treatment, where more doctors and more sophisticated hospitals cannot hope to address the fundamental issues of mass morbidity and mortality: malaria, essentially an environmental disease currently infects over 10% of children in Luanda and analysis of Luanda Cemetery Reports for 1990 indicate that 16.4% of deaths in the under 1 year age group and 16.9% of deaths in the 1 to 4 age group are due to malaria. Measles, a preventable disease is responsible for 41% of deaths in the 1 to 4 group in the same year. Diarrhoea is the third major defined category, accounting for over 8.0% deaths in both cited age groups; but it must be underlined that the single biggest category was ill defined symptoms, reflecting the limited nature of the data. The overall estimated under five mortality rate is 300/1000.
(Harpham, T and Kanji, N. 1990)

The above data serves to reinforce the argument that any community project designed to have an impact on health status must address the issues of water supply, waste disposal and sanitation. Essentially all of the major causes of morbidity and mortality are either environmentally related (malaria), related to water and sanitation or are preventable by immunisation.

Why a pilot project in a peri-urban area?

To date, poor environmental conditions, limited water supply and seriously deficient sanitation in Luanda have been described and linked to high morbidity and mortality rates. But there has been no documented experience which either serves to develop a model for future improvements or any local experience which justifies pressure on the policy makers to effect desirable changes in the operation of the existing public service network.

Why Ngola Kiluange?

Again quoting the LHHBNS, the levels of child health and nutrition in Luanda are poor by international levels and do not seem to be specifically related either to income levels or to accessibility to formal health services. Essentially, similar conditions of poor public health environment would be found in any peri-urban area of Luanda. Development Workshop elected to develop the project in Ngola Kiluange because it has an established community base in the project area: it enjoys the trust of the community built on work and a sustained presence during difficult recent years. It commands the respect of the official structures who actively seek to cooperate with the project in community development work. The major churches work with the project on areas of mutual concern particularly health.

Development Workshop has also completed a number of community studies (Annex 2 Community Studies) in their area of operation. It has a field office in Ngola Kiluange with a full-time field officer who supervises and participates in the activities of the salaried and voluntary community workers. The field officer also provides consistent support for the other emerging community groups who look to the project for support.

Support for Community Based Organisations

Expectations for peace and democratic elections have engendered various spontaneous groupings in the urban areas around issues of improving the general standard of services and the environment in the local community. The project team sees it as imperative that this independent dynamic of self-help and auto-empowerment should be facilitated rather than driven.

Voluntary groups in the community have grafted themselves on to the project structure, looking for support in planning and implementation of their activities. The project aims to assist development within the local context: it is not the intention to plan a long-term project but rather provide the grassroots structures in the community with the capacity for long term development.

2.4 Target Group

The target groups within the population are best defined for specific objectives. The project will aim to improve the quality of water for the total population (60,000); the quantity of water will be increased for the specific sub-population in Val Saroca (25,000). The cleaner environment initiative is aimed at the total population, including the development of a sustainable rubbish removal mechanism. Improvement in the quality of health services gives specific priority to the preventive health services and in this context will target the population under five and mothers in the reproductive age group.

2.5 Chronology of Project

The present project proposal is based on prior work in the Sambizanga Project Area over several years.

1986 - The Musseque Upgrading programme started informally as a joint initiative between the Development Workshop and a small group of Angolan professionals from the National Department of Urbanism and the Angolan Women's Organisation.

DW fielded a team of experts including sanitation and civil engineers to evaluate the environmental health problems in the Musseques of Luanda. Based on the mission's technical recommendations and the promise of support from the Angolan Government the Sambizanga Project was initiated in 1987.

1987 - The Minister of State for Production supported the initiative by creating the Gabinete para Rehabilitacao e Renovacao dos Musseques (GARM) as an autonomous government office with a mandate for Musseque Upgrading. GARM answered to the Ministers office and had a national mandate to coordinate multisectoral interventions in the Musseques.

1987-88 - DW provided a technical assistance team to work with GARM in an advisory and training capacity on the Sambizanga Project. Government counterpart funding failed to materialize and resistance to GARM's coordinating role was encountered at local government levels and with the key government institutions responsible for the delivery of goods and services.

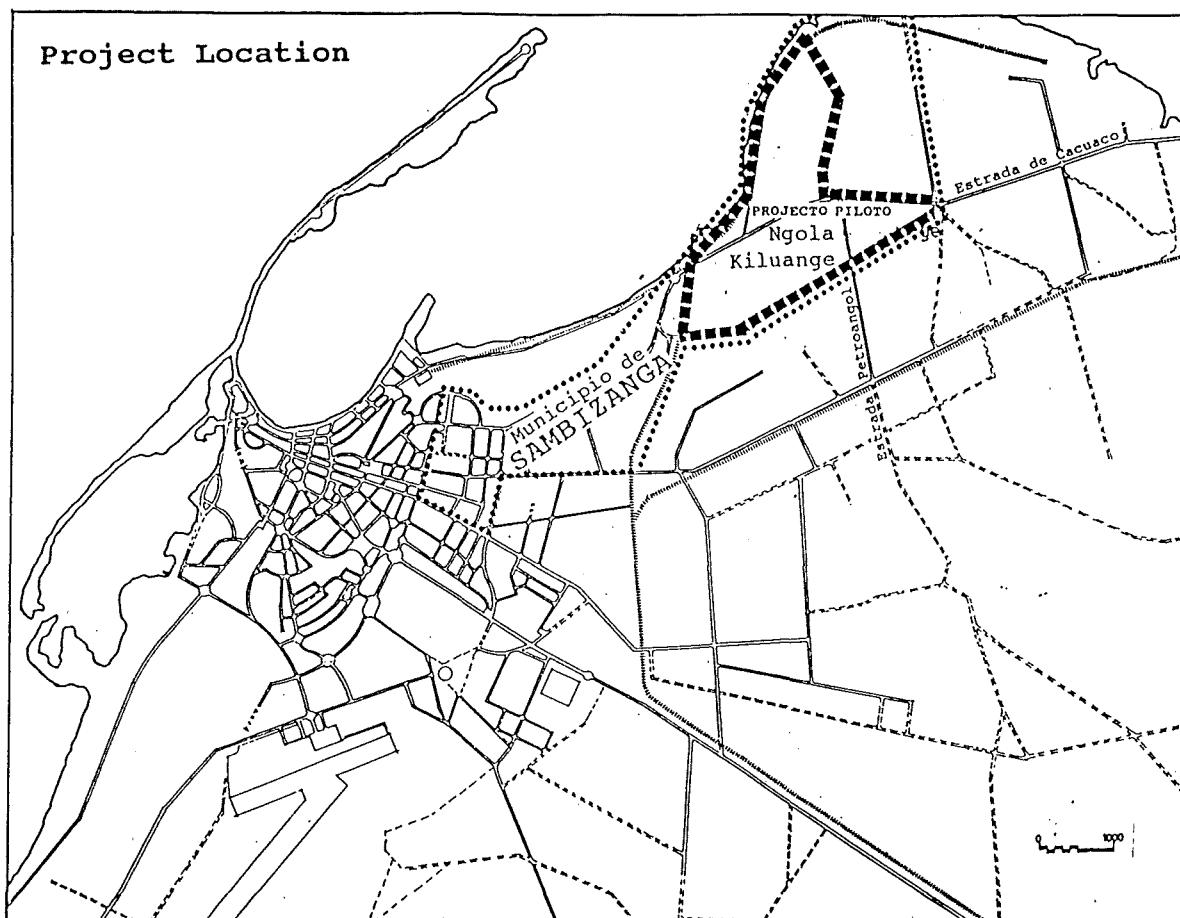
1989 - The technical assistance team began to cooperate with the Ministry of Health (MOH) which emerged as the most effective local government partner on the Sambizanga Project. A project Community Development Sector was created: basic level community workers were trained and a series of detailed sectoral studies were carried out, with the aim of redefining project priorities in line with the residents' aspirations and resources. (See Annex). The community health centre and a primary school were rehabilitated, a new health post opened and four demonstration housing units were built.

1990 - GARM was dissolved and responsibilities for urban and peri-urban improvement reverted to local government structures

of the Provincial and Municipal Commisariados (Governors Offices). As part of major political reforms the introduction of a Law of Freedom of Association led, for the first time in Angola, to the spontaneous emergence of community-based organisations (CBO's) and civic and environmental associations. DW continued to work on the Sambizanga Project with the MOH and local-level government and the new Community Based Organisations (CBO) as community project partners.

1991 - DW entered an agreement with the MOH to collaborate on a sanitation programme in Sambizanga and with the Provincial Government on a community water plan for the project area. A project committee involving community development workers (activistas), local CBO's in the project area and the technical assistance team was established and meets weekly to monitor progress and discuss project planning priorities. A project field office was opened in May 1991, 15 new community workers trained and a third health post is under construction in cooperation with the Igreja Evangelica de Angola in the project area. The first phase of the water and sanitation components of the project have begun: a water reserve tank for the area is under construction and the construction of the community atelier has been completed. A solid waste disposal programme has been in operation for three months but some significant modifications will be introduced in this proposal.

This present proposal refers to a second phase, beginning 1992.



3.0 WORKING ASSUMPTIONS

3.1 Process of Democratisation

The period 1990-91 has seen a greater degree of political openness in Angola, particularly as a result of the government's adoption of a policy of wide ranging reforms with the aim of increasing democratization. A ceasefire has held since April 1991 and future elections seem guaranteed. The atmosphere for discussion and for developing links between residents of the musseques and government departments is now positive and improving rapidly (although this could change).

3.2 Development of Community Structures

The increasing development of locally-based community structures (e.g., NGOs, CBOs, religious groups and others) means that a project can develop links directly with the community rather than operating only under the wing of a ministry or government department. There is a greater possibility, now that the mechanisms exist, for community participation in project formulation, design, implementation and management.

3.3 Demographic Parameters

This project is using the population figure of 60,000 in Ngola Kiluanje, based on an 8% population growth rate and using 1983 census figures as a base. The reasons such a high population growth rate is assumed is because Ngola Kiluanje is a relatively newer commune and formerly had a lower population density; thus, there has been a higher migration rate into this area in recent years than into other older-established and more populated parts of the musseques.

The actual population, however, is not known. The communal commissioner's office estimates there are up to 75,000 inhabitants in Ngola Kiluanje and the health centre has used the figure of 76,000 since the start of 1991. The latter figure is based on the number of people registered as residents plus their dependents, but it is generally recognized that there are other more recently arrived inhabitants who have still not registered. There has not been a detailed census since 1983. The central government, however, has been mandated to carry out a national census; the results will probably not be available until the third quarter of 1992.

The population is roughly divided between migrants of 10 years standing or more and those who have arrived more recently: language groupings are predominantly umbundu, kimbundu and kikongo. Adult illiteracy rates are high especially among women. The majority of the population do not have any official employment and of those who are regularly employed the majority fall in the category non-skilled manual labour.

3.4 Felt vs Absolute Needs

Based on the DW 1989 survey in Sambizanga, the lack of an adequate and safe water supply is clearly indicated by residents as their single most pressing problem. This project is assuming that this 'felt need' for water is also an 'absolute need', and that improving the water supply will simultaneously improve the quality of daily life and decrease problems of water-borne diseases.

Improved sanitation, on the other hand, has not been articulated by residents as a priority felt need. All objective data, however, indicates that poor sanitation conditions in the musseque are the cause of many serious health problems and therefore is classified as an 'absolute need'.

3.5 Risks

The feasibility of this project is dependent to a large extent on future political and economic developments in Angola. The current political situation is fluid: gains on the democratic front could be quickly reversed in the event of political friction being resolved militarily or in the event of overwhelming dissatisfaction on the part of the demobilised soldiers with no defined place in the peace process.

The long-term impact of structural adjustment on the socio-economic status of the urban poor is not clear. It is not apparent that there will be any dramatic increase in employment opportunities for non-skilled labourers and it certainly seems likely that buying power will decrease across the spectrum. In a free market economy services will increasingly be bought and sold and the project design must be rigorously simple and cost-effective to avoid surpassing the community's capacity to maintain infra-structural improvements.

At local level it is not yet clear whether the dynamic of development will be maintained. Grassroots politics have a growing importance but as yet there is no structure in place to allow their effective operation. If their activities are not allowed adequate place in the political development they could conceivably disintegrate. Similarly, if these organisations expand more rapidly than their functioning capacity they may become frustrated and ineffective.

3.6 Sustainability

The sustainability of the project will be specifically related to identifiable internal and external factors. The crucial external factor is the continued development of a legal and constitutional framework to facilitate the development of responsible and responsive power structures at the community level. There is widespread popular support for changes leading towards a more established democracy and an overwhelming popular

desire for peace at all costs but the process is yet vulnerable to power struggles.

The internal or project factors relate to the activists or community workers and their interaction with the community. These can be viewed in the short-term and in the long term. During the project life-time, training must respond to the individual activists need to improve themselves and increase their knowledge. Increasingly, they are measuring how effective training is by monitoring perceived behaviour changes in the community. If this momentum of training leading to better health education and positive behaviour changes in the community cannot be maintained the activists will become demoralised. The long term sustainability will depend on how effective the project will be in equipping a critical number of people in the community with the necessary skills to maintain and develop the infra-structure established during the life of the project.

4.0 OBJECTIVES

4.1 Developmental Objectives

- Improve the quality of community services in the project area and extend the access to a greater number of people.
- Develop a community based model for interventions aimed at improving public health conditions in the musseques.
- Develop the NGO partner's training and implementation capacity to assist community groups (CBO's) in urban upgrading.

4.2 Intermediate Objectives

- Develop the capacity of the community to understand health and environmental issues in relation to their daily lives in order that they press for useful and appropriate changes.
- Support the public service bodies in local interventions designed to improve living conditions and health i.e. specifically health service, ELISAL and EPAL.

It is unlikely that a community with little understanding of the link between health and environment and health and water and sanitation will be prepared to work for any useful improvements. On the other hand, public service bodies who have never had to deliver services to the musseques are not unexpectedly non-plussed by the very evident dimensions of the problems of water and sanitation in these areas. Hence the necessity to develop models of participation and cooperation in order to effect fundamental improvements in water supply and rubbish removal.

4.3 Immediate Objectives

The immediate objectives are described in three units which correspond to the implementation planning units, Community Development, Sanitation, Water and Physical Upgrading and Training. The training programme is designed to support the implementation and long term sustainability of interventions in the other two areas.

4.3.1 Training

- Develop and implement a training programme for urban community development workers in order that they will be able to form the link project - community during the project's life-time and when the project ends there will be a critical number of community members with the necessary skills and knowledge to organise the maintenance of the established improvements in water and sanitation in the area and be able to continue with the process of self sufficient community development.

- Develop and use training modules to train members of community organisations in simple office practice and planning techniques. If community organisations are to survive and develop they need basic training in order to be able to articulate their objectives and work towards selected, achievable goals. Otherwise they may become rapidly frustrated by their own inability to get anything done.

- Train members of the local community in the water and sanitation technologies promoted by the project to facilitate the introduction of new technologies and to ensure the long term maintenance of the same.

- Develop and implement an in-service training programme for health staff in the project area. This programme will concentrate on improving the quality of existing care delivered at this level and extending the delivery of preventive health services at community level. In the area of immunisation the programme aims to increase the total number of vaccines by 40% and decrease the lag between those who present for polio zero and those who complete the under one schedule by 20%. For Mother and Child Care, the programme will aim to increase the number and improve the quality of ante-natal consultations; introduce regular growth monitoring and immunisation of children presenting for any or other reasons; re-activate the diarrhoea corner and in conjunction with the activista training programme introduce screening in the community for specific problems e.g. malnutrition post-measles, diarrhoea and acute respiratory tract infections.

- Establish a training programme for local staff employed by the project to ensure their motivation during the project and improve their employment opportunities after the project.

4.3.2 Sanitation, Water and Physical Upgrading

- Improve the quality of water by

- a) Repairing and improving the existing standpipes such that better hygiene is facilitated at the point of water collection. This will affect approximately one third of the population in the project area; 15 standpipes will be renovated through the same area. The primary criteria for selection of standpipes for renovation are that the water pressure is adequate in the area to ensure water flow and that the local users are interested in having the same standpipe renovated.

- b) Establishing community based monitoring of chlorine content of bought water. This initiative is part of the provincial cholera programme and targets 80% of families in the project area who either continuously or intermittently buy water from water sellers.

- Improving access to water for a selected subpopulation of 25,000, living in the sector Val Saroca. This area has never had access to public water: a community reservoir is being built at the highest point in the area and water will be distributed to a network of 30 standpipes by gravity.
- Provide simple and appropriate water systems for the health centre and two health posts in the area.
- Develop a strategy for solid waste removal in collaboration with the community and ELISAL. The plan identifies 16 official dumps in the project area including 6 landfill sites.
- Promote the use of dry pit latrines. More than half of the population in the project area already have latrines but the majority are pour flush latrines with poor hygienic conditions. The programme will aim to make dry pit latrines desirable and affordable first options for those with no latrine and promote the same as an affordable alternative for those with blocked unhygienic latrines.
- Develop strategies for community/public service/project cooperation for filling in stagnant water pools to improve environmental conditions and facilitate access to the bairro.
- Consolidate the capacity of the Cacuaco workshop (Development Workshop) to provide the tools, materials and training to support the implementation and maintenance of the above initiatives. This facilitates community access to good quality material at an affordable price.

4.3.3 Community Development

- Support and promote the self-sufficiency of emerging community based organisations in the area. Aside from the newly emerging CBO's there has been no tradition or experience for such organisations to draw from in Angola. During the initial stages of development these groups are vulnerable and will require some formal support mechanisms.
- Facilitate the development of communication channels between the community and the service providers. Again there is no previous tradition of accountability on the part of service providers any real experiences of community participation in planning and implementation.
- Establish a Community-Project Committee in order that local control of improvements in infra-structure can be planned from the beginning.
- Develop a health education programme based on the activities of the community workers associated with the project. Active community participation will only be possible if the community have some understanding of the issues involved.

- Ensure adequate technical support for the Project Field Coordinator and the community workers supervised by this post. Interventions and activities based on newly acquired knowledge and skills require close and supportive supervision.
- Develop a model for community management for local essential services i.e. water and rubbish disposal. Without a community based monitoring system the long term maintenance of physical improvements will be jeopardised.



O desinvestimento comunitario e a estrategia principal do Projecto.

5.0 ACTIVITIES - STRATEGY

The project interventions are conceived as a bridging activity, supporting a specific community through a transition from a centrally controlled state where local decision making was weak and local initiatives often went unsupported; to a democratic state where local development will depend to a large extent on the mode of local government to be adopted and its articulation with individual communities at the municipal and comuna level. At this time of transition, the project aims to act as a catalyst for further development by helping establish a minimum functioning infra-structure and by training community members to maintain this structure in partnership with the public service institutions.

The project has attempted to establish appropriate working relationships with all four levels of government administration (see Annex 1, Problem Analysis, Section 3.1.2 for a detailed discussion of Administrative Structures) and with community structures and their leaders at the base. The Ministry of Health has been the key national level partner, since the demise of the Ministry of State apparatus and GARM. While the Ministry of Health's Directorate of Public Health provides a policy umbrella for many of the Project's community health programmes, the functional partners are the Provincial level Public Health Department and the health centre staffs at the municipal and commune levels.

The National Water Directorate is also a partner in policy matters in its own sector although the provincial water company EPAL is the Project's designated working partner.

Within the urban administration the principal partner for policy related matters is the Vice Governor for the Technical Sector, responsible for urban services and physical planning. The effective lowest level of the urban administration is the Municipal Governor and his assistants who, though lacking access to necessary resources for effective execution, provide an important link into the government service structure.

5.1 Training Component

The training component is designed in order to ensure the sustainability of the community initiatives begun with project support. Development Workshop intend to use the training experience to produce a manual for training of community development workers in urban areas and to reinforce their own capacity to train for development at the level of the community. Whereas community projects are rarely totally replicable, depending on such inherently diverse factors as cultural and geographical origin, community skills and literacy, local environment and geology, socioeconomic status and potential, essentially lessons will be learned which will provide the raw material for developing functional models for upgrading in the hitherto neglected peri-urban conglomerations of Luanda.

5.1.1 Training of Activistas:

The training programme will accompany the project activities in water, sanitation and education for health. It is envisaged that the training programme will be modified and continue to develop as a result of the training experiences and feedback from the trainees. This process is considered imperative in order to facilitate the introduction of teaching methods based on problem solving and trainee participation. These methods are not commonly used in Angola and frequently meet with considerable resistance from participants. Hence the emphasis in this programme will be on enabling people to do something they want/need to know how to do, accompanying them during an intervention and reviewing the act and the results following the intervention.

The programme will be developed in modular form: projected modules are:

- Water and Sanitation
- Primary Health Care
- Communication, Organisation and Management
- Civic and Community Action

This concept makes it possible for individuals or organisations to participate in or use specific modules without being obliged to use the full programme. A case in point is the Angolan Red Cross who wish to participate in the design of the modules - Training for PHC and Education for Health - such that they may be integrated into their training programme for field officers.

5.1.2 Continuing Education for Health Personnel

Recognition of the need for further training of the health personnel followed on the increase in numbers of patients using the health centre as a result of health education done by Activistas on house to house visits. There were also instances where people were lead to believe that a specific intervention was both desirable and possible and the same intervention was not forthcoming. It became apparent that interventions made by qualified health staff were inappropriate or too late. This observation combined with information gathered using Rapid Appraisal techniques suggested that training should concentrate on priority services and specific functions. Hence, this component will concentrate on mother and child care and immunisation services. The trainer will agree with the health staff on themes related to specific problems and activities in their normal work. Teaching techniques will include problem analysis in the context of their community, use of flow charts and management of common presenting problems in conjunction with the teacher/trainer on a regular basis.

5.2 Sanitation & Physical Upgrading Component

5.2.1 Community Water Supply

The steps in the development of this component of the project are the following

1. Identification of appropriate and possible interventions: a series of studies were completed to establish what was technically feasible and what was acceptable to the community.

2. Discussions with the community: these took place in 1990, via the Bairro Committees at the level of - quarterao -. These discussions served to provide the community with feedback on the studies and directed the selection of suitable interventions.

3. Technical and Implementation Planning: The technical design was done in 1991 by Development Workshop and consultants. Implementation planning is done jointly by the technical assistance team, project activists and the community.

This project component is the most advanced to date; a plan for the reserve water tank and water points has been designed and the tank is under construction. Similarly, work has begun on the improvement of existing standpipes in areas where water pressure is adequate to ensure a minimum water supply. Major civil construction is done under contract; installation work i.e. preparing channels and digging soakaways is done with voluntary labour with the participation and supervision of the project engineer.

The issue of cost recovery, an inextricable part of such a community water project, is being developed in parallel with the work on the physical structure. The principle is fully endorsed by the community but the mechanisms are still being explored. There are two factors which of necessity frame any approach to cost recovery

1. those who currently have access to public water, regardless of the quantity or quality have never payed for the water

2. those who to date have never had access to public water are perfectly willing to contribute in labour but less willing to contribute money until water is flowing.

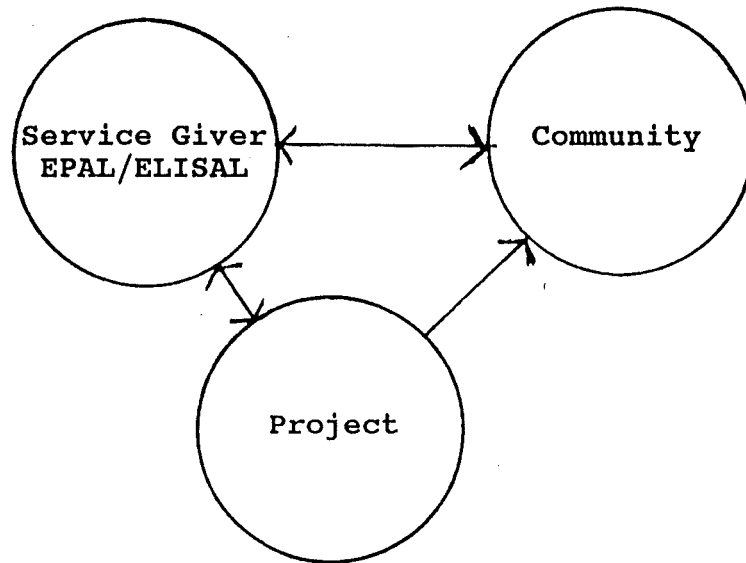
The project plans a short term consultancy to examine the issue in greater detail and to develop a feasible model with the community for long term management of the standpipes and water system.

5.2.2 Solid Waste Disposal

The project and the community are currently negotiating an agreement with ELISAL, the new State company with the responsibility for solid waste disposal in Luanda. The previous agreement with ENTRACO had proved difficult in practice but the

current management of ELISAL are actively looking for ways to begin servicing peripheral Luanda. The plan developed with ELISAL also involves the infill of some of the most eroded areas of the project and improvement of access roads permitting entrance of rubbish removal vehicles into the project disposal sites.

The water and sanitation components of the project function in a triangular structure:



In this triangular relationship, characteristic of the Project modus operandi, the Project provides technical backup and resources where these are necessary to achieve the objectives of the programme and are not available from either of the other partners.

5.2.3 Improved Latrines

The concept of improved latrines will be disseminated through the community development component of the programme. The project however plans to make available a limited number of latrine construction components such as improved slabs and pit liners for demonstration purposes. The project further plans to train interested members of the community in the manufacture of latrine components with the aim of encouraging local production.

5.3 Community Development

The community development sub-project is where all the project components meet. The activists represent the community but they also facilitate project access to the community. They are also being trained to provide that crucial operating link: Community / Service Givers. In this context some activists become specifically involved in sub-sections of the programme: at the moment this applies to water and latrines. In the health sector it will extend to immunisation and domiciliary follow-up for malnourished children.

The implementation of the programme will be supported by two specific local postings:

- the project coordinator in Ngola Kiluange who is responsible for management of the activists and the development and maintenance of links with the community and with other community organisations and structures
- the head of the community workshop who will coordinate the service and training functions of the workshop

5.3.1 Community Links

Development Workshop, through the project supports other organisations in the community currently contributing to the same community's development. This support involves training in simple management and planning, support in developing simple project proposals, support in accessing funds for the same. D.W. also actively promotes contacts between CBOs in the project area and organisations with similar interests in other areas in Angola and in the Southern African region.

5.3.2 Community Workshop

The community workshop, already equipped and functioning, will concentrate on making the technology for making dry-pit latrines available. This workshop services the project: it maintains a group of five apprentices on staff. These apprentices are selected from the community on criteria of previous experience in community work and on demonstrated interest in acquiring manual skills. Their training is intended to equip them with skills in the areas of water, sanitation and maintenance technologies.

6.0 INPUTS

The inputs are described for the three implementation components of the project: Training, Sanitation and Physical Upgrading and Community Development. Where (DW) or (NGO) follows an input it indicates that the same is an input which Development Workshop or one of its NGO partners brings to the project and is not included in the budget presented to UNICEF.

REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?
				1	2	3	
6.1.1.1	TRAINING PERSONNEL	Expert Technical Assistance	Public Health Specialist (half time input)	X	X	X	UNICEF
			Training Coordinator (half time input)	X	X	X	UNICEF
			Short Term Consultants	X	X		UNICEF
6.1.1.2		Local Staff	Training Instructors	X	X	X	UNICEF
			Public Health Technician	X	X	X	UNICEF
			Graphic Artist- Designer	X	X		UNICEF
			Translator - Typist	X	X	X	UNICEF
			Driver (half time input)	X	X	X	UNICEF
6.1.2.1		TRAINING EQUIPMENT	Audio Visual	Slide Projector (Kodak Carousel), audio-visual synchronization, lenses, case, accessories 250 W.	X		
	Projectn Screen- Daylite			X			UNICEF
	Light Table			X			UNICEF
	Video Camera- Recorder, Video Console Multi-Syst Large Screen Monitor, Antenna, Signl Amplifier 25 Video Film Cassettes			X			UNICEF

REF.No.	INPUT	ITEM	SPECIFICATION	Year Needed?			By Who?		
REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?		
				1	2	3			
6.1.2.2	TRAINING EQUIPMENT	Pedagogical Equipment	Over-Head Projector for transparencies	X			DW		
			Flannelgraphs (5 each) • Teaching Aids at Low- Cost (UK) • AIDS (AALSIDA specify)	X			UNICEF		
			Whiteboards (3) 1 x 2 m.	X			UNICEF		
6.1.2.3		TRAINING EQUIPMENT	Computer Equipment	Computer AT-386 100-MB Graphics Capability	X			UNICEF	
				Printer Graphics Quality	X			UNICEF	
				UPS Backup Power Supply input 12-36 volt battery min. 500 Watt capacity	X			UNICEF	
				Software - Desk Top Publ graphics, wordprocessing Accessories, Discs/Cables	X			UNICEF	
6.1.2.4			TRAINING EQUIPMENT	Communication Equipment	(4) Radios - two way Walkie Talkies	X			UNICEF
					(4) Rapid-Chargers accessories and battery	X			UNICEF
	(4) Antennas & Cables				X			UNICEF	

REF.No.	INPUT	ITEM	SPECIFICATION	Year Needed?			By Who?
REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?
				1	2	3	
6.1.2.5	TRAINING EQUIPMENT	Office Equipment Furniture	(2) Filing Cabinets 4 dr (500) Hanging Files	X			UNICEF
			Manual Typewriter (Port.)	X			UNICEF
			(2) Airconditioners	X			UNICEF
			(3) Ceiling Fans	X			UNICEF
			(2) Water Filters	X			UNICEF
			(6) Desks & Chairs	X			UNICEF
			(2) Steel Locking Cabnts	X			UNICEF
			(4) Drafting Tables	X			UNICEF
6.1.2.6		Reproduction Equipment	(30 sets) Work Clothes	X			UNICEF
			Photocopy Machine medium duty load, sorter back-to-back option access. & serv. contract	X			UNICEF
			Gestetner Dupl. Machine	X			DW
			Electronic Stencil Cuttr	X			DW
			Silk Screen Frame & Acs.	X			UNICEF
Binding Machine	X			UNICEF			

REF.No.	INPUT	ITEM	SPECIFICATION	Year Needed?			By Who?
REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?
				1	2	3	
6.1.2.7	TRAINING EQUIPMENT	Installations	Classroom with furniture for 15 to 20 students	X			DW
6.1.3.1	TRAINING MATERIALS	Reproduction	250 Reams A4 Paper 50 Reams A3 Paper	X	X	X	UNICEF
			50 Reams A4 Colour Card 10 Reams A3 White Card	X	X	X	UNICEF
			10 Reams A1 paper 5 Reams A1 draft paper 10 Reams A1 White Card	X	X	X	UNICEF
			500 Notebooks	X	X	X	UNICEF
			1000 Pencils/Pens/Eraser	X	X	X	UNICEF
			50 Rulers 30cm & 10 x 1m	X			UNICEF
			10 set Drafting Material	X	X	X	UNICEF
6.1.5.1		Publications	Texts, Reference Books	X	X	X	UNICEF
			Subscriptions, Journals	X	X	X	UNICEF
6.1.5.2		Printing	Manuals, Posters	X	X	X	UNICEF
			Workshop Installations	X			DW

REF.No.	INPUT	ITEM	SPECIFICATION	Year Needed?			By Who?
REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?
				1	2	3	
6.1.6.1	SCHOLARSHIPS TRAVEL	Exchanges	In-Country 7 placements for 15 days	X	X	X	UNICEF
			In-Region 7 placements for 20 days	X	X	X	UNICEF
6.1.6.2		Language Courses	12 placements	X	X	X	UNICEF
6.1.6.3		Scholarships	Community Development Short Courses external	X		X	UNICEF
			Project Planning/Admin Short Courses external	X	X		UNICEF
			Public Health 3 months external		X		UNICEF
			Technical Workshop Short Training courses external	X		X	UNICEF
6.1.7.1	TRANSPORT	Vehicle	Landrover 4x4 longwheel- base, stationwagon, desiel, model-110	X			UNICEF
			Spare Parts, Insurance, Running Costs, Servicing	X	X	X	UNICEF

6.2 SANITATION AND PHYSICAL UPGRADING INPUTS

REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?
				1	2	3	
6.2.1.1	PERSONNEL	Expert Technical Assistance	Programme Manager Urbanist/Architect	X	X	X	UNICEF
			Water Supply Technician	X	X	X	UNICEF
			Short Term Consultants	X	X	X	UNICEF
6.2.1.2		Local Staff	Workshop Manager	X	X	X	UNICEF
			Chief Mechanic	X	X	X	UNICEF
			Construction Technician	X	X	X	UNICEF
			(8) Apprentices	X	X	X	UNICEF
			(7) Guards	X	X	X	UNICEF
			Draughtsman	X	X	X	UNICEF
6.2.2.1	EQUIPMENT	Construction Equipment	Trench Digger, back-hoe, front end loader	X			UNICEF
			Site Dumper	X			DW
			Water Trailer	X			DW
			Block Making Machine	X			DW
			Woodworking Machine	X			UNICEF
			Cutting Torch	X			UNICEF
			Power Hack-Saw	X			UNICEF
			Rubbish Containers	X			UNICEF

6.2 SANITATION AND PHYSICAL UPGRADING INPUTS (continued)

REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?
				1	2	3	
6.2.2.2	EQUIPMENT	Tools	Carpentry & Power Tools	X			UNICEF
			Latrine Mould Kits (20)	X			UNICEF
			Masonry (12 kits)	X			UNICEF
			Pipe Fitting	X			UNICEF
6.2.2.3		Safety	Protective Clothing	X			UNICEF
6.2.2.4		Office	Typewriter (Portuguese)	X			UNICEF
			Furniture - cabinets, desks, chairs, tables	X			UNICEF
			Air Conditioners (2)	X			UNICEF
			Drafting Machine (equip)	X			UNICEF
6.2.2.5		Communications	Radios Two-Way, Walkie-Talkies (4)	X			UNICEF
	Rapid Chargers, Antennas Cables & Accessories (4)		X			UNICEF	
6.2.2.6	Computer	Desktop AT-386, 100MB	X			UNICEF	
		Printer with Graphics Capabilities	X			UNICEF	
		Software- Project Manag. Spreadsheet, Data Base	X			UNICEF	
		UPS Power Backup - 500 W	X			UNICEF	

6.2 SANITATION AND PHYSICAL UPGRADING INPUTS (continued)

REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?
				1	2	3	
6.2.2.7	EQUIPMENT	Installations	Workshop Facility for appropriate technology development & production	X			DW
			Maintenance Facility for project equipment	X			DW
			Warehouse Space for storage of project material & equipment	X			DW
			Drawing Office	X			DW
6.2.3.1	MATERIALS	Consumables	Saw blades, welding rods	X	X	X	UNICEF
6.2.3.2		Construction Materials	Cement 6 200 bags/month	X	X	X	UNICEF
			Sand and Gravel	X	X	X	UNICEF
			Water Pipes and Fittings	X	X	X	UNICEF
			Steel Profiles & Timber	X	X	X	UNICEF
			Paint & Protective Matrl	X	X	X	UNICEF
			Hardware	X	X	X	UNICEF
		Maintenance, repair & cleaning materials	X	X	X	UNICEF	
6.2.3.3	Stationary	Drafting & Stationary	X	X	X	UNICEF	

6.2 SANITATION AND PHYSICAL UPGRADING INPUTS (continued)

REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?
				1	2	3	
6.2.4.1	SERVICES	Construction Contracts	Workshop Extensions	X	X	X	UNICEF
			Repair Project & Social Facilities	X	X	X	UNICEF
			Waterline implementation	X	X	X	UNICEF
6.2.6.1	TRAVEL	Visiting Consultants	(2) Return Tickets	X	X	X	UNICEF
		Home Leave	Expatriate Tech. Staff	X	X	X	UNICEF
6.2.7.1	TRANSPORT	Vehicles/Trucks	Flatbed Truck 5-8 MT	X			UNICEF
			Landrover 4 x 4 pickup	X			DW
			Landrover 4 X 4 station	X			DW
			Dump Truck 10 MT	X			DW
			Motorcycle	X			DW
			Spare Parts & Repairs	X	X	X	UNICEF
			Insurance	X	X	X	UNICEF
			Running Costs & Fuel	X	X	X	UNICEF

6.3 COMMUNITY DEVELOPMENT INPUTS

REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?
				1	2	3	
6.3.1.1	PERSONNEL	Expert Technical Assistance	Public Health Specialist part-time input	X	X	X	NGO
6.3.1.2		Local Staff	Community Development Coordinator	X	X	X	NGO
			Community Development Workers/Activistas (12)	X	X	X	NGO
			Driver	X	X	X	NGO
6.3.1.3		Consultants	Locally and Externally Recruited	X	X	X	NGO
6.3.2.1	EQUIPMENT	Tools	Community Tool Deposit	X	X	X	NGO
6.3.2.2		Site Office	Typewriter (Portuguese)	X			NGO
			Furniture & Machines	X	X	X	NGO
6.3.2.3		Health Centre	Fridge for Vaccines	X			NGO
			Sterilisers	X	X		NGO
			Diagnostic/Curative	X		X	NGO
6.3.2.4		Communications	Radios Base/Mobile 5W	X			NGO
			Chargers & Accessories	X	X	X	NGO
6.3.2.5	Reproduction	Audio-Visual	X	X	x	NGO	
6.#.2.6	Installations	Project Field Office & meeting place	X			MINSA	

6.3 COMMUNITY DEVELOPMENT INPUTS (continued)

REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?	
				1	2	3		
6.3.3.1	MATERIALS	Food-for-Work	Basic food packages to subsidize community works projects	X	X	X	DW	
6.3.3.2		Consumables	Supplies for Activistas	X	X	X	NGO	
6.3.3.3		Stationary	Office Supplies		X	X	X	NGO
			Paper A4 (250 reams)		X	X	X	NGO
			Poster Materials		X	X	X	NGO
6.3.4.1	SERVICES	Media	Public Dissemination	X	X	X	NGO	
		Studies	Surveys & Questionnaires	X	X	X	NGO	
			Statistics and Data Processing	X	X	X	NGO	
6.3.4.2		Improve/Repair	Community Facilities	X	X	X	NGO	
6.3.5.1	EXTENSION	Publications	Project Library	X	X	X	NGO	
			Printing	X	X	X	NGO	
		Exchanges	In-country Excursions	X	X	X	NGO	
			In-Region Proj.Exchanges		X	X	NGO	
6.3.6.1	TRAVEL	In-country	Field Trips	X	X	X	NGO	
		Visiting Consult	Air Travel & Accomodatn	X	X	X	NGO	
		Home Leave	Expatriate Tech Assist.	X	X	X	NGO	

6.3 COMMUNITY DEVELOPMENT INPUTS (continued)

REF.No.	INPUT CATEGORY	ITEM	SPECIFICATION	Year Needed?			By Who?
				1	2	3	
6.3.7.1	TRANSPORT	Motorcycles	(6) units for use of community development activistas on proj.site	X			NGO
			Spare parts & repairs	X	X	X	NGO
			Running costs & fuel	X	X	X	NGO
			Insurance	X	X	X	NGO

7.0 OUTPUTS

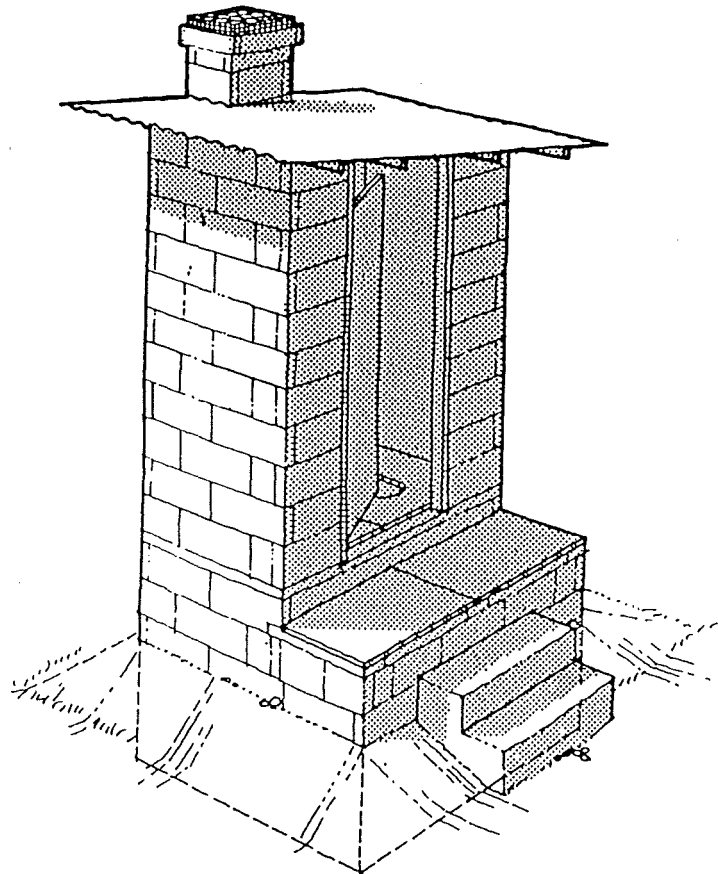
The outputs are again described for the three implementation components of the projects: the presentation of each component is in tabular form.

7.1 SUB-PROJECT: TRAINING OUTPUTS

COMPONENT	OUTPUT	SPECIFICATIONS
ACTIVISTAS	Training Programme	identification of training needs
		cooperation agreements with other training organizations
		review existing national training materials
		preparation additional training materials
		training curriculum
	Trained Community Development Workers	training programme
on-going supervision of programme as part of training		
COMMUNITY ORGANIZATION	Skills in basic Planning, Accounting and Management	identify training needs
		review existing training materials & resources
		preparation of new training materials & curriculum
	Improved Capacity Self Management & Sustainability	training programme
		ongoing supervision & advisory support

COMPONENT	OUTPUT	SPECIFICATION
HEALTH PERSONNEL	On-the-job Training	identification of needs with emphasis on: <ul style="list-style-type: none"> • preventative care • screening • early intervention • positive follow-up • rational prescriptn • interpret informatn
		collaboration agreements with other training organizatns
		joint supervision with level 3 care givers where possible
MAINTENANCE	Maintenance Schedule Functional	identification of training needs in social facilities
		preparation of training material
		training programme
		supervision in collaboration with community organizatns or local government
WORKSHOP	Community Members Trained in Sanitatin & Water Technology	selection of candidates
		training candidates
		follow-up supervision
	Evaluation Reports	monitoring tools for above components
FUNDED TRAINING	Activistas	English Classes for 10 activistas
		3 month training for coordinator
	Health Personnel Middle Level	Teaching PHC one person 3 months
	Health Personnel Third Level	Managing PHC or Epidemiology one person 9 months

COMPONENT	OUTPUT	SPECIFICATIONS
FUNDED TRAINING	Workshop	workshop management training one person 3 months
	Project Administration	office management one person 3 months
	Trainee Exchange	4 trainees each two week placements per year; - 2 placements on in-country projects - 2 placements on regional projects



7.2 SUB-PROJECT: SANITATION AND PHYSICAL UPGRADING OUTPUTS

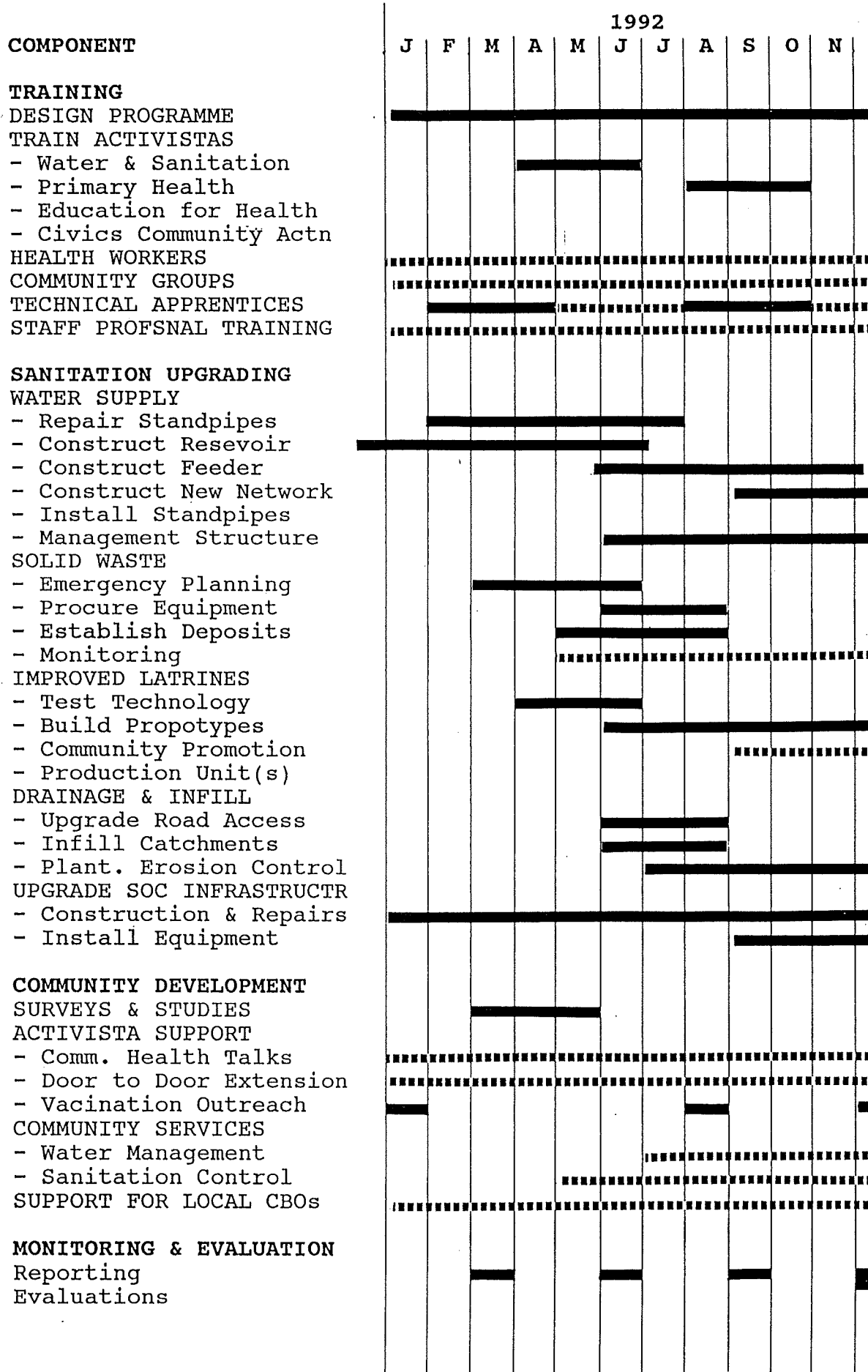
COMPONENT	OUTPUT	SPECIFICATION
WATER	Upgrade Access to Water of Improved Quality	survey of existing water sources and methods of transport, storage, household uses and disposal
		plan for disinfecting cisterns and tankers
		community based monitoring system to ensure quality maintenance
	Rehabilitated Existing Water Network in Older Sectors of Comuna	survey map of the existing and derelict standpipes and lines of old network
		policy on clandestine and private household connections
		water management committee for planning construction maintenance & funding
		trained technicians & promoters for implementation and monitoring of system
		model of standpipe which ensures hygenic collection of water and controls run-off
		rehabilitation or upgrading of 10-15 existing standpost sites.
	Instal New Network of Standpipes in Unserved Sectors of the Comuna	plan of water supply system based on appropriate standpipe locations
		water management committee
		trained technicians, promoters & monitors

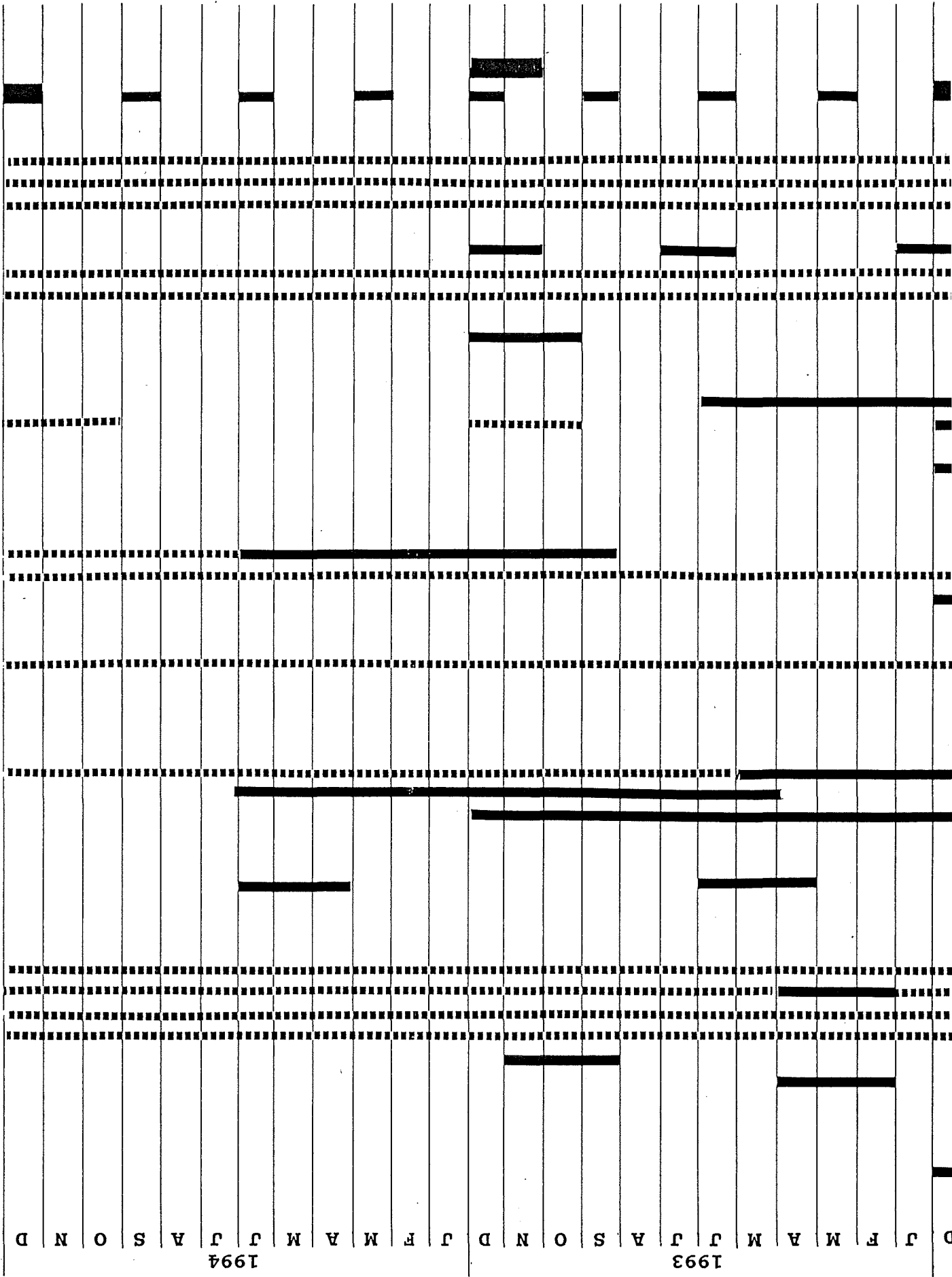
COMPONENT	OUTPUT	SPECIFICATIONS
WATER (cont.)	Install New Network of Standpipes in Unserviced Sectors of the Comuna	water reservoir (header tank) to fill at night to provide daytime pressure
		distribution system serving 10-15,000 people
		20-30 water distribution points with double standpost
		monitoring and maintenance system
		cost recovery mechanism
	Evaluation Reports	monitoring tools
		info base for future project planning
SANITATION	Improved Environmental Hygiene	emergency plan for disposal of existing rubbish
	Sustainable System of Waste Disposal	long-term plan for rubbish disposal
		working agreement with ELISAL including specification of responsibilities to supervise & monitor
HEALTH FACILITIES	Improvement of Health Facilities Coverage in Comuna	repair and upgrade Ngola Kiluange Health Centre
		repair exist. H. Post
		construct new H. Post
		equipment for above
		water and waste disp. systems for H. Facil.
	Preventative Maintenance Plan	maintenance schedules
		training & implement.
ROADS	Maintain Access to Bairro Facilities	agreement with ELISAL to infill depressions

7.3 SUB PROJECT: COMMUNITY DEVELOPMENT OUTPUTS

COMPONENT	OUTPUT	SPECIFICATIONS
COMMUNITY DEVELOPMENT TEAM	Project Field Office	project field office opened in May 1991
		equipment for office
		recruit community development coordinator
		strategy for community participatn in public health, water and sanitation
		recruit community development workers
		recruit volunteer activists
		weekly door-to-door visits
		community defined priority projects
HEALTH EDUCATION	Immunization Water & Sanitation Hygiene Nutrition	public education using mass media
		community theatre
		collaboration through local structures ie churches & schools
		household visits
		publications, posters
ENVIRONMENT AWARENESS	Improved Quality of Environment	assessment of environmental problems
		public education
		youth clubs & schools
		rubbish cleanup promotion & campaigns
COMMUNITY ORGANIZAT'NS	Sustainable Locally Managed Associatns Clubs, Churches	field office provide logistic support & institution building
		support for local initiatives, projects

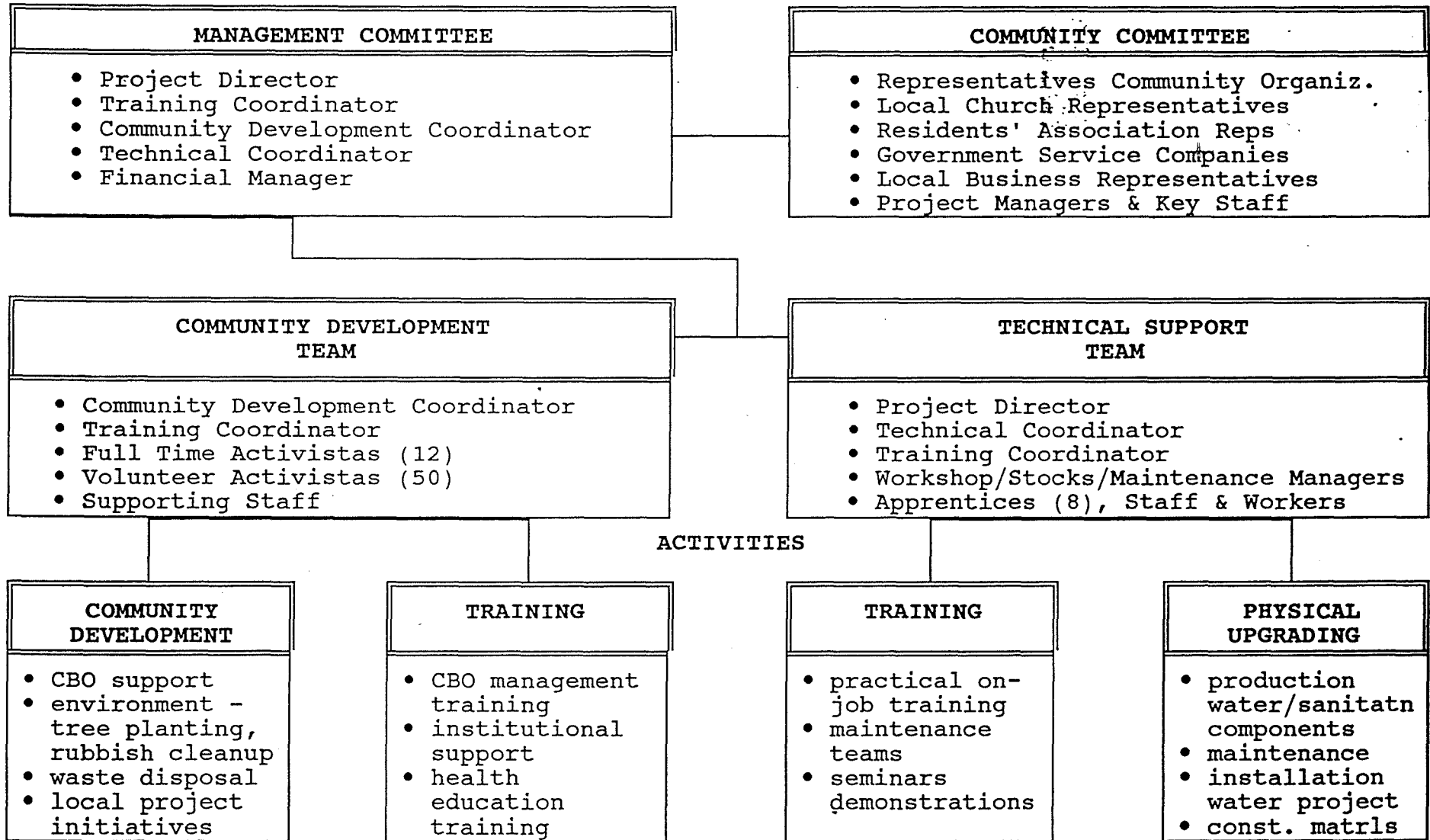
8.0 PLANNING SCHEDULE





9.0 PROJECT STRUCTURE

ORGANIGRAM



10.1 Reporting

Monthly activity reports will be required from the field for each of the sub-projects

- Training
- Sanitation and Physical Upgrading
- Community Development

These reports will confine themselves to activities planned / resources required and activities completed / problems encountered.

The Quarterly Internal Management Report will analyze the monthly reports with reference to indicators and achievement of immediate objectives. This report should also refer to any major problems or external factors which affect the development of the project.

The annual report should place immediate objectives on a time scale of achievement of development objectives: this report should indicate any revision of the original project plan with justification. Consequent alterations in objectives should be detailed in this report.

10.2 Evaluation

Project planning envisages an external evaluation in the last quarter of 1993. The results of this evaluation should dictate the mechanism and timing of a planned withdrawal of project support to the community of Ngola Kiluange.

10.3 INDICATORS

IMMEDIATE OBJECTIVE	QUANTITATIVE INDICATORS	QUALITATIVE INDICATORS
TRAIN URBAN ACTIVISTAS	Training Modules Completed as per Schedule	Assimilation of information. Level of comprehension
	Number of Activistas Trained	Depth of awareness of health and development issues
	Number of household visits	Level of community awareness of issues
	Number of public talks/demonstrations	Activista communication skill Level of community participation
SUPPORT FOR COMMUNITY ORGANIZATIONS	Number of meetings planned and completed	Capacity gained in planning and management
	Number of community organizations to associate with proj.	Local requests for support for community projects
IMPROVE ACCESS TO CLEAN WATER	Number of water reservoirs tested for chlorine	Reduced incidence of cholera
	Reservoir completed within budget	Lower proportion of household income spent on water
	Number of standpipes repaired & upgraded	
	Number of standpipes installed	Reduction of water-borne diseases in project area
	Numbers of people served	Increased consumption of water per capita
	Number of litres of water / person / day	
	Number of water committees	Regular preventative maintenance Reduced vandalism Reduced losses due to clandestine connections

IMMEDIATE OBJECTIVE	QUANTITATIVE INDICATORS	QUALITATIVE INDICATORS
DELIVERY OF HEALTH SERVICES	Number of consultations per health worker	Correct diagnosis and prescriptions
		Quality spot checks of consultations
	Numbers of patients attending the health service per day	Greater community satisfaction in health services
		Greater confidence in health workers
Increase support in allocation of resources by official structures		
IMPROVED SANITATION	Number of latrine slabs produced per month	Introduction of latrine production technology
	Number trained techs	
	Number of latrines constructed or improved	Public acceptance of the need for improved sanitation
		Requests for info or assistance on improved latrines
		Improve hygiene standards of new latrines
		Reduction in incidence of waste related disease
	Number of rubbish deposits created	Effective cooperatn with ELISAL
		Community use of specified deposits
	Quantity of rubbish removed per month	Improvement of environmental hygiene, reduce vermin, flies and associated diseases
		Reduction quantity or elimination of accumulated rubbish

11.0 IMPLEMENTATION PLAN

REF.	ACTIVITIES	TIME FRAME	RESPONSIBILITY	INPUTS
11.1	TRAINING			
11.1.1	TRAINING ACTIVISTAS	ongoing		
11.1.1.1	Water-Sanitation Module	3 months		
	Trainig Needs Assessment		DW	
	Design Curriculum		DW	
	Compile Resources		DW, UNICEF, GOV	
	Select Participants		ComDev	
	Run Course		DW	
	Assessment (feedback)		DW, Activistas	
	Produce Manual		DW	
11.1.1.2	Primary Health Module			
	Trainig Needs Assessment			
	Design Curriculum			
	Compile Resources			
	Select Participants			
	Run Course			
	Assessment (feedback)			
	Produce Manual			

IMPLEMENTATION PLAN (continued)

REF.	ACTIVITIES	TIME FRAME	RESPONSIBILITY	INPUTS
	TRAINING (continued)			
11.1.1.3	Educate for Health Mod.			
	Training Needs Assessment			
	Design Curriculum			
	Compile Resources			
	Select Participants			
	Run Course			
	Assessment (feedback)			
	Produce Manual			
11.1.2	TRAINING HEALTH WORKERS			
	Training Needs Assessment			
	Design Curriculum			
	Compile Resources			
	On Job Training			
	Short Seminars/Demos.			
	Assessment (feedback)			
11.1.3	TECHNICAL APPRENTICES			
	Training Needs Assessment			
	On-job Training Plan			

IMPLEMENTATION PLAN (continued)

REF.	ACTIVITIES	TIME FRAME	RESPONSIBILITY	INPUTS
	TRAINING (continued)			
11.1.4	TRAINING COMMUNITY GROUPS			
	Identify Groups			
	Training Needs Assessment			
	Design Short Courses			
	Compile Resources			
	Run Seminars & Courses			
	Follow-up on-job			
	Assessment (feedback)			
11.1.4	PROFESSIONAL STAFF DEV.			
	Training Needs Assessment			
	Identify Training Courses			
	Short Term Courses			
	On-job Follow-up Training			
	Continuous Assessment			

IMPLEMENTATION PLAN (continued)

REF.	ACTIVITIES	TIME FRAME	RESPONSIBILITY	INPUTS
11.2	SANITATION UPGRADING			
11.2.1	WATER SUPPLY			
11.2.1.1	Needs Assessment/Survey			
	Propose Alternatives			
	Discuss with Community			
	Technical Design			
	Assemble Resources			
	Repair Exist.Standpipes			
	Construct Reservoir			
	Construct Feeder Line			
	Construct New Network			
	Install New Standpipes			
	Management/Maintenance			
	Assessment (feedback)			
11.2.2	SOLID WASTE			
	Emergency Clean-up			
	Assemble Resources			
	Establish Deposits			
	Ongoing Monitoring			

IMPLEMENTATION PLAN (continued)

REF.	ACTIVITIES	TIME FRAME	RESPONSIBILITY	INPUTS
11.2.3	IMPROVED LATRINES			
	Needs Assessment/Study			
	Technical Options			
	Build & Test Prototypes			
	Community Promotion			
	Production System			
	Assessment (feedback)			
11.2.4	DRAINAGE & INFILL			
	Upgrade Road Access			
	Infill Catchments			
	Plant. Erosion Control			
11.2.5	UPGRADE SOC. INFRASTRUCTR			
	Construction & Repairs			
	Install Equipment			
	Maintenance Plan			
	Monitoring			

IMPLEMENTATION PLAN (continued)

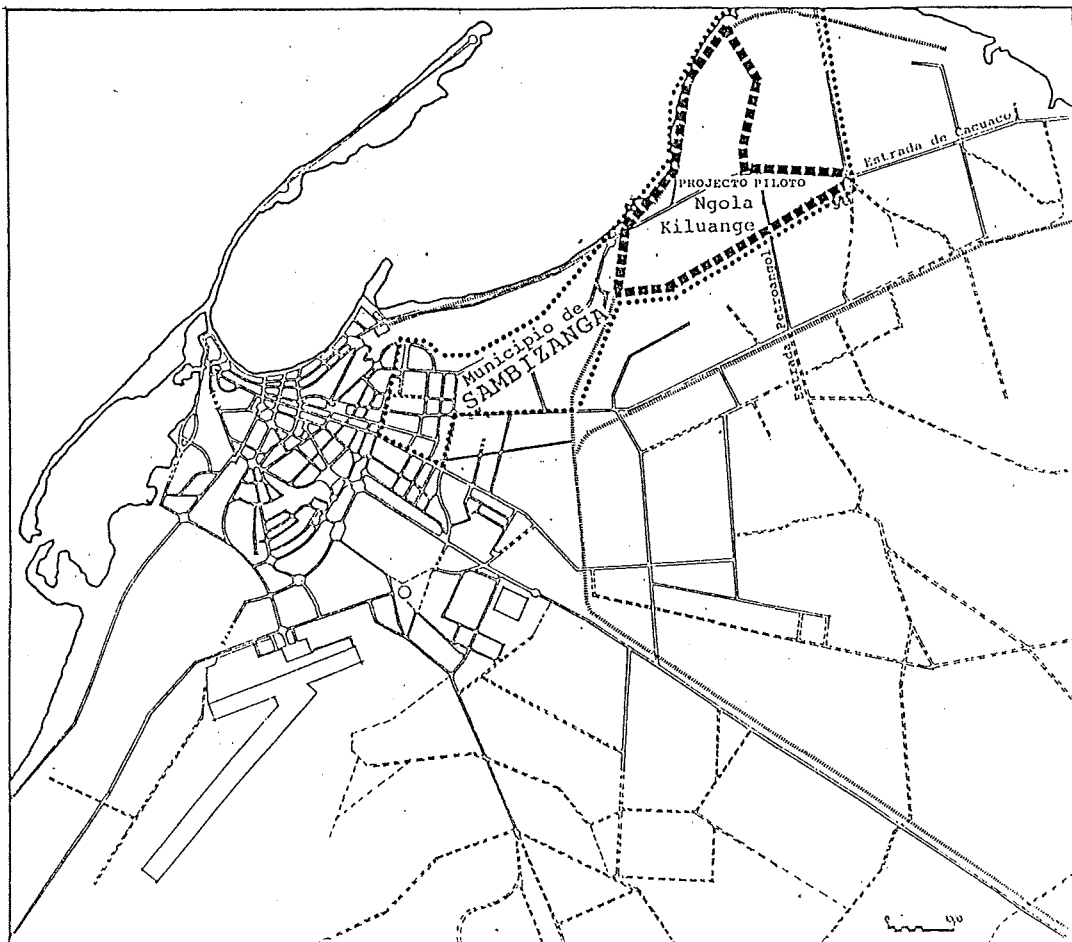
REF.	ACTIVITIES	TIME FRAME	RESPONSIBILITY	INPUTS
11.3	COMMUNITY DEVELOPMENT			
11.3.1	SURVEYS & STUDIES			
	Resource Assessment			
	Problem/Need Assessment			
11.3.2	ACTIVISTA SUPPORT			
	Public Health Talks			
	Household Visits			
	Vaccination Outreach			
11.3.3	LOCAL PARTICIPATION			
	Weekly Meetings			
	Project Committee Meet.			
	Water Management Commit			
11.3.4	SUPPORT FOR LOCAL CBO's			
	Tool Loan Deposit			
	Fund Local Initiatives			
	Management Support			
11.4	MONITORING & EVALUATION			
11.4.1	Reporting Schedule			
11.4.2	Evaluations			

ANNEXES

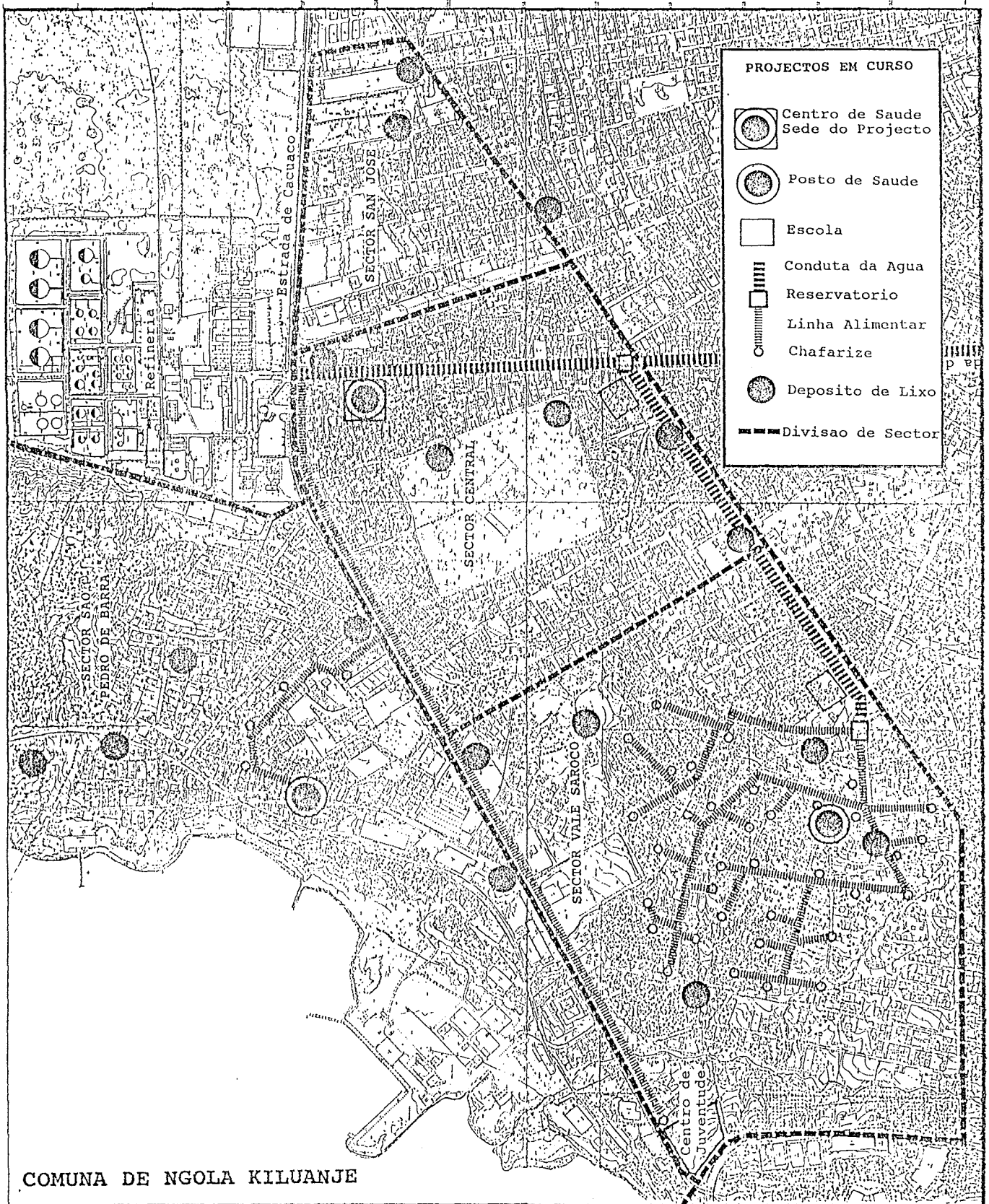
ANNEX I: PROBLEM ANALYSIS

1.0 PROBLEM STATEMENT

Luanda continues to expand rapidly in area and density of population concentration. Population estimates of up to 2,000,000 are broken down into 500,000 in the urban area (3,000 ha) and 1,500,000 in the peri-urban areas (10,000 ha). The population annual growth rate is projected at 8% to 10%, although there is evidence in some Musseque areas, such as that of the Project, of 15% growth rates. Peri-urban communities have no infrastructure and recognisable public services function only in the area of health and education. These existing services, however, have disintegrated through a combination of neglect, lack of maintenance policies and lack of appropriate expertise. These problems are further compounded by limited funds for either maintenance or expansion. Recent major state investments in rehabilitation / extension of the infrastructure have had little impact to date on the quality of service delivery. Community structures are weak but undergoing a rapid transformation, the direction of which is not yet clear.



2.0 THE SAMBIZANGA PROJECT PILOT AREA - ANALYSIS



2.2 TARGET GROUP ANALYSIS

Demographic information in this section is drawn from the 1983 Luanda census except where stated otherwise. This section gives an overview of the characteristics of peri-urban populations in Luanda with specific reference to and comparison with the project zone.

2.2.1 High Urban Growth Rate

Angola's annual population growth rate of about 2.6% per year does not reflect what has actually happened in the country, in particular the high rural to urban migration due to recent war-related factors. World Bank estimates show an urban population growth rate for the 1980's at 7.6% per year, while the rural population growth rate for the same period was estimated at 0.8% per year. (World Bank 1988:2-3) Extrapolations from government statistics indicate an annual growth rate of over 8% in some of the fast-growing bairros like Ngola Kiluanje.

Table 1 indicates a population breakdown for Ngola Kiluanje by age-group, resembling that of any other developing country.

TABLE 1

RESIDENT POPULATION IN AGE-GROUPS 1983 CENSUS

Age-Group	Total	Male	Female
	26,804	13,707	13,097
0-4	6,254	3,172	3,082
5-14	7,055	3,468	3,587
15-39	11,462	5,913	5,549
40-54	1,583	944	639
55-64	273	135	138
65-75+	177	75	102

Applying an 8-10% growth rate to the 1983 census figures, the current population for Ngola Kiluanje is estimated to be between 50-57,000 inhabitants or double what it was eight years ago. Local estimates from the Comuna Commissioner of Ngola Kiluanje set the population at 85,000 persons indicating a possible growth rate of as high as 15% per year. It is hoped that the election census planned for 1992 will help clarify the real population growth rate in Luanda's musseques.

2.2.2 Changing Origin of Population

Table 2 shows the area of origin of the respondents; this indicates a socio-demographic feature consequent on war provoked migrations; nearly half the population are born in Luanda whereas the remainder are from other provinces.

TABLE 2

PROVINCE OF ORIGIN 1983 CENSUS

Province	Number	% of total
Luanda	11,290	42.6
Malange	4,633	17.5
Bengo	4,564	17.2
Uige	1,418	5.3
Huambo	1,263	4.8

Although the 1989 DW water survey did not ask respondents to indicate their province of origin, information obtained indicates that 19% of respondents came to live in their existing premises from outside Luanda, 31% came from other municipalities within Luanda and 50% came from other locations within Sambizanga municipality. Of the approximately 160 households interviewed for each of the sanitation and water surveys (13% of the total number of 1,250 households in the sample area), 61.8% had moved to the area during the last five years (since 1984), and 28.7% in the last six to ten years (1979-84). This reflects the fact that the population is comparatively new to the area. Of the total sample, the language groups in 1989 were as follows:

- 56.0% Kimbundo
- 20.1% Umbundo
- 21.4% Kikongo
- 2.5% Songo

Considering only language group, there has been a significant shift in population composition in Ngola Kiluanje during the period 1983 to 1989. According to the 1983 census, Ngola Kiluanje had the following language group breakdown six years ago:

- 45.5% Kimbundo
- 11.2% Umbundo
- 11.0% Kikongo
- 32.3% other languages

It is noteworthy that the minority language groups in Ngola Kiluanje - Umbundo and Kikongo - have virtually doubled during this period, again indicating a large rural in-migration into the area. This in-migration is not just numerical; it also means

that a larger percentage of the Ngola Kiluanje population have socio-economic characteristics more similar to rural than urban dwellers, e.g., higher illiteracy rates.

2.2.3 Increasing Household Size

The 1983 census for Ngola Kiluanje showed there were 5,043 family aggregates with an average of 5.3 members per aggregate. Of these 5,043 family aggregates, 326 (6.5%) are composed of only one person. The 1989 DW study sanitation and water study found that on average, there were 7 people per household (family and kin members).

2.2.4 Female-Headed Households and Women Alone

The 1983 census also showed that 10.6% (534) of the total number of family aggregates consisted of female-headed households.

There are also many women on their own in Ngola Kiluanje. According to the 1983/84 census, almost three-quarters of those who are separated (715 of 1,004) or widowed (276 of 365) are women.

2.2.5 The Elderly

The elderly - men and women - are among Angola's "invisible people". As Table 3 shows, 1990 population estimates (UN) show there are more elderly women in Luanda than elderly men. It is perhaps just a coincidence that in 1983, there were equal numbers of elderly men and women in Ngola Kiluanje.

TABLE 3

ELDERLY IN ANGOLA:
LUANDA AND NGOLA KILUANJE
50+ YEARS OF AGE

Sex	1990 estimates	1983 census
	Luanda % of total pop.	Ngola Kiluanje % of total pop.
total	3.9	2.7
men	1.9	1.4
women	2.0	1.4

Traditionally, elderly are treated with great respect and deference. This may be changing in urban areas where more and more elderly find themselves abandoned and must fend for themselves.

2.3 HEALTH STATUS INDICATORS

The fertility rate in Angola is 6.4 live births/woman. Angola has a high mother-and-child mortality rate. In 1990, infant mortality was 15% in the first year of life, the national maternal death rate was 6.7%, and Luanda's maternities had a maternal death rate of 10.4%, one of the highest in the world. Over 1/4 of maternal deaths occur among women 15-19 years old. Maternal and infant deaths are related to women's poor health (malnutrition, infections & parasitic diseases) and the lack of adequate health care facilities in peri-urban and rural areas.

2.4 SOCIO-ECONOMIC STATUS

2.4.1 Employment: Gender Patterns

■ Luanda

The 1983/84 census showed that in Luanda, 78% of men and 22% of women were economically active in the formal sector. The largest percentages of women were employed in administration and services, and as workers: 6% and 5% respectively. For men, they were most active as workers, technicians and in administration and services: 33%, 11% and 10% respectively.

■ Ngola Kiluanje

Table 4 below shows the 1983 breakdown of formal sector employment for those who have been resident 10+ yrs in Ngola Kiluanje. There are striking differences of employment patterns between this commune and Luanda as a whole. First, women constitute only 12% of those formally employed. Second, the largest percentages of women were employed in the service industry and as office workers: 32% and 20% respectively, whereas men were most active as non-skilled workers and as office workers: 65% and 12% respectively.

TABLE 4

**ECONOMICALLY ACTIVE
(RESIDENT 10+ YRS)
1983 CENSUS**

Work Category	Total	Male	Female
Total	5,789	5,075	714
scientific / technical	397	317	80
public / private admin	10	10	-
office workers	732	586	146
merchants / shopkeepers	217	104	113
service industry	695	466	229
agriculture, small-scale	315	277	38
animal husbandry, forestry, fishing & hunters			
non-skilled workers with exception of agric & services	3,423	3,315	108

What is clear from Table 4 is that the majority of the population are employed in non-skilled or semi-skilled jobs. The 1983 census also showed that about two-thirds of the total number of households in Ngola Kiluanje have only one economically active member. Of the 326 single-person households in the commune, 84 (25.8% of one-person households) are not economically active, i.e. people living on their own with no means of support.

■ Food Supply Cards and Structural Adjustment

The Sitios Sentinelas, 1990, Luanda was done in Cassenga, a neighbouring bairro to Ngola Kiluanje. There 49% of the surveyed population had one food supply card and 13% had two or more cards. Hence, it is clear that the peri-urban populations, though marginalised in terms of urban services, are very much part of the urban workforce even in the formal sector.

Recent salary adjustments (November 1991) which markedly raised pay scales leaves the minimum salary rate at 12,000 Kw. Ministry of Agriculture information for November 1991 indicates that a family of five in peri-urban Luanda, with no supply cards, require 157.000 Kws for minimal food security. Hence in practice most families have members involved in numerous activities, both in the formal and informal sector, in order to survive. What is not yet clear is how the structural adjustment programme will affect individual domestic incomes or what the employment opportunities will be for the predominantly non-skilled workforce in peri-urban Luanda.

2.4.2 Illiteracy and Gender

Illiteracy is still a serious problem in Angola. The 1983/84 census in Luanda and the coastal provinces showed the following illiteracy rates for those 15 years old and over:

TABLE 5

ILLITERACY RATES
15+ YEARS OF AGE
1983 CENSUS

Area	Total (%)	Men (%)	Women (%)
Luanda	27.3	11.4	44.4
Ngola Kiluanje	31.3	7.5	23.8
Coastal zones	50.4	33.9	63.7
urban	40.5	24.4	54.6
rural	61.3	45.5	72.9

Table 5 shows there is a higher illiteracy rate in rural areas than in urban areas, and that in both areas the illiteracy rate for women is higher than for men; the same pattern exists in Ngola Kiluanje.

The 1983/84 census also showed that the highest illiteracy rates are found among the elderly of both sexes. As Table 6 shows, again illiteracy is higher in the rural areas, and among women in both urban and rural areas. The fact that the elderly illiteracy rate is higher in the commune of Ngola Kiluanje than in Luanda as a whole may be another indication that during recent years, there has been a lot of displacement from rural into urban areas, with Ngola Kiluanje being one of the main catchment areas in Luanda.

TABLE 6

ILLITERACY RATES
40+ YEARS OF AGE
1983/84

Area	40-49 years old (%)			50+ years old (%)		
	Total	Men	Women	Total	Men	Women
Luanda	43.4	21.8	71.8	60.0	38.5	80.0
Ngola Kil	53.5	30.7	88.6	72.0	50.7	93.5
Coastal zones	72.9	51.0	91.7	85.7	74.0	96.0

The 1983 census shows 75.8% of female-headed households were illiterate compared to only 20.1% of male-headed households.

The project area in Ngola Kiluanje reflects the characteristics of the more recent peri-urban Musseques where large sections of the population have arrived within the previous 10 years from rural areas; increasing population growth rates result from natural growth and migration; high illiteracy rates in the adult populations reflect their rural origins. Illiteracy in the economically active sections of the population further reduce their employment opportunities. Poor infrastructure and services in these areas correspond to a prevailing impression that these settlements are transient: but both studies done in neighbouring African countries and current trends in Angola suggest that any outward migration from the cities will continue to be amply compensated for by continuing rural-urban migration.

3.0 PUBLIC SERVICES

In order to achieve its objectives the project must collaborate effectively with the public service deliverers. This section makes an analysis of the relevant public service sectors: Urban Administration, Health, Water and Sanitation.

3.0.1 LUANDA AND URBANISATION: AN INTRODUCTION

Luanda's distinctive urban structure evolved due to a lack of effective colonial planning policy: the spontaneous townships ("musseques") were encapsulated by formal sector urban growth. Following independence peri-urban uncontrolled extension, as seen in other African cities, began. To-day, well over a million people live in either the high density old musseques or the peri-urban mushrooming suburbs. Neither area has ever received any investment in infrastructural development and the original infrastructure designed to meet the needs of 250,000 Portuguese in the colonial era is totally inadequate today.

Government actions to date have not been sufficient in maintaining the existing infra structure left from colonial times. While major infrastructural projects have been planned to extend water and electricity to a greater number of people, little has been implemented and the targeted beneficiaries have normally been those living in formal already urbanized zones of the city. There has to-date been no discernable impact from these planned projects on living conditions in the musseques; in fact the situation has deteriorated with rising population densities as the minimal infrastructure falls into disrepair.

On the policy level, there has been a reluctance to invest in the musseques which are seen as transitional settlements destined for replacement once resources become available for new housing development. Government housing policy has been two-pronged. The majority of resources have been invested in imported industrialized housing systems, generally multi-storied (4-5 floors) apartment types. It is estimated that during the period 1977-89 about 3,500 dwellings have been constructed at the rate of 270 units per year. In addition, government policy calls for support for self-help construction through the 1980 publication of the law on "Auto-Construcao". The policy calls for the allocation of serviced plots and sale of building materials at subsidized prices to low-income families. The small amount of building materials allocated to the programme, the limited technical capacity of local government departments responsible for implementation of the programme and the unavailability of services such as water and sanitation has meant that results are limited to one or two projects for the settlement of returning refugees at Palanca and Viana II. *review this?*

The current if limited recognition of the need for upgrading in the musseques in Luanda dates from the creation in 1986 of a small office - GARM, Office of Upgrading and Rehabilitation of

3.2.2 Structure

The health sector comprises three distinct administrative levels, Central, Provincial and Municipal.

Ministry of Health

- Central Referral Hospitals
- Instit. of Public Health
- State Companies
 - Angomedica
 - Medicang
- National Blood Bank and Hemotherapy Centre
- Centre for Oncology
- Post Graduate College

Prov. Delegation of Health

- Provincial Hospitals/
Regional Hospitals
- Municipal Hospitals
- Middle Level Training Institutes
- Provincial Training Schools for
Basic level Health Technicians

Municipal Delegation of Health

- Municipal Health Centre, Urban and Rural
- Health Posts
 - Community Health Workers
e.g. Promotores de Saude
- Traditional Birth Attendants

3.2.3 Functional Analysis

The system functions with three care levels:

Level 1	Level 2	Level 3
Health Post	Provincial Hospital	National/Referral Hospitals
Community Health Workers	Municipal Hospital	Regional Hospitals
	Health Centres	

In practise Primary Health Care functions (Level 1) are performed at Levels 2 and 3 because of lack of facilities and poor quality of care at Level 1.

At the National Level there already exists inherent limitations to efficient functioning of the health system. Harpham,T and Kanji,N (undated) for the London School of Tropical Medicine enumerate a list of functional problems with their genesis in the MOH. They can be seen in the larger groups of

- weak policy with frequent changes
- central decision making with poor implementation capacity
- low staff morale
- poor training with no career structure
- unit base, technician centred health care models.

Peri-urban Health Care suffers from a concentration of the same problems with even less financial resources and poorer quality human resources to attempt an improvement in the quality of the services.

The Luanda Provincial Health Delegation had 2,348 employees in 1991. The total is broken down into 57 doctors, 340 middle level technicians and 817 basic technicians; the remainder, 1,134 are accounted for in the category administration and services (a figure representing 42% of the total). A further breakdown of the category -Middle level Technicians- shows that 53% of the same are -tecnicos medios equiparados-, essentially basic level technicians who have been promoted on criteria of experience and performance. Hence at Provincial level the number of health staff with a professional qualification equivalent or higher than middle level training account for only 18% of the total staff.

Most of the doctors in Luanda are concentrated in Hospitals or in Administration: junior doctors assigned to peri-urban health centres view appointments as a shortlived obligation prior to climbing onto the real career ladder in hospital medicine. They function, often newly qualified, without any support or supervision and frequently in relative isolation to other Primary Health Care activities in their centres. Supervision at this level in the health structure is seen uniquely as a function of vertical programmes, if it exists at all.

3.2.3.1 Project Area - Ngola Kiluange

■ Health Facilities

The comuna of Ngola Kiluange, with an estimated population of 85,000 has one Health Centre in the Sector Central and a Health Post in the Sector Sao Pedro de Barra. The Igreja Evangelica de Angola is building a second health post in the Sector Vale Saroca with Project Sambizanga support.

The physical structures in all cases are functional and in a good state of repair. The Health Post in Sao Pedro de Barra is in a converted dwelling house; both working and waiting space are adequate with excellent natural light. The other health units were purpose built.

■ Services

The effective opening hours are 08.00 hrs until 12.00 hrs. The first hour is devoted to registration; a spot check on registration records indicates that the maximum number of consultations per staff member on any one day is 10 and the more frequent patient flow averages at 5 consultations per technician per day. The most used service is the immunization service; this is a recent trend, following the initiation of health education by the Project Activistas.

The service facilities in EPI are adequate in the HC with the exception of needles and syringes which have long past their life span of 200 sterilisations. The Health Post has no pressure cooker and cannot therefore sterilise material. Ante-Natal Care clinics are done without a stethoscope, measuring tape or sphygmomanometer. The Paediatric section has an Oral Rehydration section with the minimum material. General Medical consultations are done in the "Emergency Department": simple dressings and injections are done in the same section and there is no real emergency service.

Patients theoretically have access to the laboratory service in the Municipal Health Centre in Sambizanga. In practice this access has been limited by the use of strict and limited daily quotas.

■ Quality of Care and Records

The quality of care is poor; patient assessments are superficial with infrequent attempts to take a case history or examine the patient. Patients are given blanket treatments in relation to their symptoms; multiple prescriptions of similar medicines are the rule. Screening and referrals are arbitrary and no attempt is made to follow-up patients.

Existing records are patient held i.e. immunisation cards, Road to Health cards and ante-natal care cards.

Routine information is reported monthly. It includes that determined by vertical programmes such as EPI; malaria and diarrhoea cases are reported without an age breakdown; the number of consultations in each service is also recorded. This information is reported monthly to the Municipal Delegation of Health.

■ Medical Supplies and Outreach Services

The medicines in the Essential Medicines Programme are received regularly with support from the project.

Out-Reach Services are not common in Angola with the exception of immunisation campaigns. The Accelerated Programme of Immunisation no longer includes campaigns as a strategy, hence most health units no longer perform any outreach service whatsoever.

■ Private Clinics

The main services provided in the informal sector are urban transport (controlled by men), education and health. Because many state schools and health institutions are not working and/or working conditions are poor, many teachers and nurses (many of whom are women) have left the formal sector and teach or do basic health care in their homes for payment.

A recent study by DW attempted to detail the functioning private sector activities in the bairro: it included five private full-time clinics run by trained nurses. All five provide similar services i.e. consultations for adults and children, circumcisions and dressings. Generally the price for specific services ranges between 2,500-5,000 Kws. Some types of treatment have specific price tags such as a measles consultation which can apparently command rates up to 18,000 Kws/consultation.

3.2.3.3 Private Medicine / Cost Recovery

To-date private medicine has not been legalised in Angola: but there are a considerable number of clinics run by private companies for their employees. Some clinics have contractual arrangements with non-associated companies to provide employees of these other companies with stipulated services.

The National Health Service continues to offer a free health service to all Angolan nationals, irrespective of earnings. (In fact many foreigners enjoy services at the expense of the state as there is no provision for payment for services under any circumstances.) But in many cases, the consumer actually pays for the service by giving money directly to the health technician performing the service; these kinds of cash transactions in no way benefit the health service which remains chronically underfunded.

Recently, a token attempt at cost recovery was introduced by charging for documents such as Road to Health cards and immunisation cards. The charge is nominal at 100 Kws but on the other hand curative services continue to be offered freely. It has also not been defined how this money should be used and by whom.

3.2.3.4 Disease Profile

The following epidemiological data has been compiled from the report "Situacao de Sector de Saude em Angola", 1990, prepared by the World Health Organisation in Luanda unless otherwise stated.

TABLE 7

PRINCIPAL CAUSES OF DEATH IN LUANDA 1989 (Registration of causes of death in the cemetery records).

Cause	% total deaths	Mortality rates per 1000 cases
Malaria	19.4	5.6
Measles	12.0	92.4
Ill-defined causes	11.2	-
Diarrhoea	8.5	14.6

Other infectious diseases with significant mortality rates are indicated in Table 8.

TABLE 8

INFECTIOUS DISEASES AND CORRESPONDING MORTALITY RATES

Disease	Mortality/1000 cases
Meningitis	528.9
Neonatal Tetanus	501.4
Tetanus (other ages)	260.7
Pulmonary Tuberculosis	79.3
Cholera	52.6

Again, in Luanda during the year 1989, 35% of the registered deaths were in the age-group 0-11 months.

A further breakdown of deaths, specifically for the age-groups <1 and 1-4 is shown in Table 9: the percentages shown are percentages of the total deaths in the same age group. The data was extracted from the cemetery notifications for Luanda, 1990. This indicates that malaria is the single greatest killer in the under ones and measles accounts for more than 40% of deaths in the 1 to 4 year olds.

TABLE 9

CAUSES OF DEATH AND THEIR CORRESPONDING % OF THE TOTAL..1990

	<1	% total	1-4	%total
Total deaths annually	6322			
Diarrhoea	544	8.6%	458	8.1%
Measles	684	10.8%	2312	41%
Malaria	1038	16.4%	945	16.9%
Cholera	63	0.9%	97	1.7%

The other causes of death are in the categories Tetanus, Acute Respiratory Diseases, Hepatitis, Ill-defined symptoms and others. Ill-defined symptoms and others combined account for the major single grouping in these age-groups.

Essentially, any impact, in the short or intermediate time range, on the health status of the population will be effected through comprehensive immunisation and provision of minimal water and sanitation services. Primarily, diseases with significant mortality rates can either be dealt with through immunisation, i.e., measles, tetanus and tuberculosis or are water and sanitation related, i.e., cholera, diarrhoea and malaria.

3.3 WATER SUPPLY

Water is the top priority felt need for the vast majority of people in Luanda's musseques (96.3% of the respondents in a 1989 DW project survey gave water as their prime concern). Access to water is severely restricted and the quality is poorly controlled and often contaminated. DW has compiled a series of documents covering community health and technical considerations concerning this sector which should be seen in annex to this document. All these studies conclude that community water supply should be the focal point of any musseque development project.

3.3.1 Policy

As with other key service sectors Angola has lacked a coherent policy on water supply, maintenance and development. Water regulations inherited from the colonial government have generally been left intact and the pricing structure has changed little from that time.

In urban areas householders, businesses and industries officially registered as users pay for the volume of water used on a metered basis. In the case of Luanda the urban network serves, on an individual user basis, only the previous colonial residential areas and the industrial and business districts. Informal residential areas, the musseques, were served only by standpipes or communal water collection points most of which were installed during the colonial era. It has been government policy not to introduce a payment system for water obtained from public standpipes. Few standpipes have been built since independence and there has been only limited extension of the colonial grid.

Luanda is supplied by surface water collected from the Bengo River through two catchment/treatment systems having a total installed capacity of 200,000 cubic meters per day. Construction of a third catchment system is underway to bring a further 26,000 cubic meters per day from the Kwanza River at Kikuxi to Viana. Only about half of the installed capacity or about 100,000 cubic meters per day can be used due to shortage of equipment and maintenance difficulties, and a further 40% is diverted in the green belt zone before it reaches the city, meaning that only about 60,000 cubic meters per day is actually available for urban consumption. Current demand on the other hand is estimated by EPAL to be between 450,000 and 500,000 cubic meters per day. Some of this shortfall is covered by commercial truckers who collect cisterns of water at the Bengo river and sell it untreated at high prices from door to door in informal residential areas. ✓

The National Directorate of Water (DNA) has indicated that legislation is presently being prepared to regulate the water sector. It is also hoped by the DNA that international financing will be attracted to invest in this sector. The World Bank proposes to make funds available for engineering and feasibility studies and institutional support for the water sector. The World Bank's stated objectives are to ensure that services should be

provided on the basis of "equity criteria, cost recovery and consumer participation". It may be assumed that these criteria will be adopted by DNA as a basis for their new sectoral policy.

3.3.2. Structure

Sectoral responsibilities for water have not been clearly defined and have been passed from one state authority to another during the years since independence. There has not been, nor does there exist at the time of writing, a clear articulation of responsibilities between the national and local government levels. Sectoral responsibilities have in recent years passed from the Ministry of Construction to the Secretary of State for Urbanism, Housing and Water. Since May 1991 the responsibility has rested with the National Directorate of Water (DNA) within the new Secretary of State for Energy and Water. DNA is mandated to provide planning and technical management to projects in the water sector and to coordinate exploration of new sources, the development of water distribution plans and oversee construction and maintenance plans for these networks. Responsible for both the rural and urban sectors, DNA has provincial Delegations in key provinces and hopes to extend this to a national network.

Execution and management of water projects, however, has not been in DNA's hands. The national company for water exploration, Hidrominas, has been part of the Ministry of Industry and only recently has been transferred to DNA. Urban water distribution and maintenance is the responsibility of the Luanda Provincial Water Company (EPAL) under the Luanda provincial government jurisdiction.

Investments in the water sector are coordinated through the National Directorate for Investments and Construction (DNIC) of the Ministry of Plan. It is through this structure that the World Bank will coordinate their investment programme for Infrastructure Rehabilitation Engineering.

3.3.3 Functional Analysis

The city of Luanda does not have the capacity to supply every household with individual connections. The city receives an average of 20.6 litres of water per person per day. Even this amount is not equitably distributed with musseque dwellers receiving on average only 5 litres per day compared to 90 litres/person/day on average in the urbanized zone of the city.

✓ The DW 1989 survey in Sambizanga indicates that people use between 5-50 litres per day: the average is 15 litres per person per day. Studies in Africa show that standpipes regulate the consumption of water to approximately 20 litres per person per day: therefore in a situation such as Luanda where water is limited, standpipes offer a more equitable solution to water distribution given that they are properly situated. World Bank policy concerns for a more equitable access to services and

resources suggest that standposts may offer at least a viable short-term solution.

Currently, there are two functioning standpipes in the Ngola Kiluange area: in the case of one, the nearest neighbour apparently claims ownership rights and sells the water. When no water is available people beg or buy; most people have to regularly buy water. Apart from the time and effort involved in looking for and carrying water, water restriction affects the latrines. The majority of latrines in this area function with a pour flush system which can use up to 10 litres per flush; surprisingly, most people claim to use clean water for this operation.

It is clear that ultimately any major improvements in the water supply depend on improved management and technical expertise in the city water supply achieving a reduction in the current leakage. It may be still several years before the needed major investment in expanding the city's catchment and treatment capacity will allow major extensions to the urban network. In the short term, immediate local improvements can be made to water access by repairing and upgrading the network in the musseques and strategically situating new standpipes to better serve existing communities.

Because of policy constraints, public standpipes have produced no income to the water authority. In turn little investment has gone into standpipe development or maintenance. Methods of cost recovery should be explored to ensure that income is available to finance the maintenance of public water points.

Until major investments are made available and an institutional restructuring takes place, the water company EPAL will have limited technical capacity to undertake even small-scale maintenance projects. Community participation in the financing, implementation and maintenance of local-level water projects must be explored as a way of supplementing the weak official institutions.

Pilot water supply projects at the community level must address the above stated objectives; more equitable access, cost recovery and community participation.

3.4 SANITATION SERVICES

3.4.1 Policy

Urban sanitation breaks down into three interrelated problems; solid waste removal, excreta disposal and drainage of sewage and waste water. There is no clearly enforced policy on sanitation in Angola but there is a growing consensus that the problem has reached a critical dimension threatening the health of the whole of the urban population.

No system based approach yet in response.

The accumulation of solid waste in Luanda worsened through the mid-1980's as the inherited colonial systems broke down under increasing population pressures. Local government attempted to attack the problem by organizing public clean-up campaigns, and commandeering private and state company vehicles to remove rubbish from the centre of the city. The results of these actions were temporary at best, and had almost no impact on the musseques. It became clear that in order to seriously approach the problem significant investments would have to be made. (see DW document "Emergency Sanitation Plan for Luanda's Musseques").

The Luanda provincial government subsequently launched an Emergency Sanitation Project in 1988 and hired a foreign contractor to manage and staff the programme. The project involved investment in vehicles and waste containers and a plan to set up several rubbish disposal land fill sites on the periphery of the city. Existing land fill sites both formal and informal in the city were closed and levelled. Urban residents were obliged to carry their household rubbish to the nearest container which was ideally within reasonable walking distance from the home. Spacing of containers related to the social composition or wealth of the neighbourhood. Lack of sufficient funds to meet needs of the whole city meant that some musseques were not allocated containers. While the programme had limited impact on musseques zones it was quite successful in controlling the accumulation of rubbish in the formal zones of the city.

suggest for musseques.

It is government policy to broaden this service to the whole city. A provincial-owned company, ELISAL, has recently been organized (1991) to take over the project from the foreign contractor, with the aim of not only saving foreign exchange but employing Angolan labour and managers.

Policy on managing excreta and waste water disposal has been inherited from the colonial period. Housing in most formal sector residential areas have septic tanks installed. Colonial legislation still used insists on the installation of a septic tank with any new construction. The city's small fleet of pump trucks is responsible for regularly cleaning these tanks. The official policy therefore promotes water borne systems of excreta disposal. A few zones of the city have piped sewage disposal systems for carrying away septic tank effluent, but most septic tanks flow directly into the stormwater drains, whether they be piped or open ditches. The existing sewage network discharges

both black and grey water directly into the sea and the Luanda bay without treatment.

✓ Dry pit latrines do not meet local by-laws which specify water borne sewage options. Due to lack of sufficient water in most parts of the city and the absence of a working drainage system to carry away liquified waste, the Ministry of Health has adopted a policy of promoting the use of pit latrines. The Provincial Government has effectively set aside the by-law provisions for musseque areas by giving limited material support to the latrine programme. Dry pit latrines are often not immediately accepted at the community level because the concept directly contradicts the previously promoted policy of water borne sanitation.

The government is presently seeking major investments from the international community in extending Luanda's formal sewage system and building the first treatment plant. Priority is to be given to the "Baixa", the central urbanized zone of the city.

3.4.2 Structure

Sanitation is a Provincial Government concern. While the National Public Health Department of the Ministry of Health sets policy and training guidelines in this field, it is implemented through the Provincial Delegate's public health office. The Latrine Promotion Programme is a joint action between the Health Delegation, the technical department of the Provincial Governor, and the local office of the World Health Organization (WHO) with NGO support from the Development Workshop.

Major foreign investments in sewage system construction are coordinated through the Ministry of Plan in conjunction with the Provincial Governor's technical office.

The solid waste disposal programme is under the management of ELISAL, the new provincial-owned company. A state company with a certain autonomy but lacking any means of cost recovery, ELISAL's budget is tied to the provincial government's office for community services.

Most Municipalities including Sambizanga maintain small brigades employed by municipal community service departments to clean roads and thoroughfares. These teams, largely women, are poorly equipped and often lack support from other levels of government.

3.4.3 Functional Analysis

This includes a summary analysis of excreta disposal and solid waste disposal. The sanitation and water survey, 1989, indicates that more than $\frac{3}{4}$ of the population in the Sambizanga area have latrines. The majority are pit offset latrines which as already stated require a pour-flush mechanism. Most latrines have single pits; the life-span of such a pit is maximum 10 years and it blocks without any prior warning. The owner is then faced with the choice of getting the toilet unblocked by the city council services (Luanda has an estimated 60% of its population using pit latrines; one can expect that 17,500 of these need unblocking annually. The City Council empties approximately 2000 annually) or building a second pit. Both options involve a significant delay.

Water borne sanitation has been promoted as the model since colonial times. The pour-flush wet pit latrine design so often seen in the musseque is an adaptation of this septic tank model. The wet pit when it fills and overflows presents a serious problem, especially in the rainy season, since faecal matter then spills directly into pathways and open drainage ditches. The poor absorbability of the clay soils prevalent in over 50% of Ngola Kiluanje adds to the problem. The fact that since 1988 Ngola Kiluanje has been one of the principal foci of successive cholera epidemics illustrates this problem.

Well-built dry pit latrines, cheaper to construct, taking longer to fill up and more quickly neutralizing dangerous pathogens, overcome many of the inherent problems of the more commonly used wet types. The acceptance of dry pit latrines has proven problematic. Their simplicity of construction is assumed by many to indicate an inferiority technologically. Public education and promotion are necessary to overcome this perception.

how low? the what?

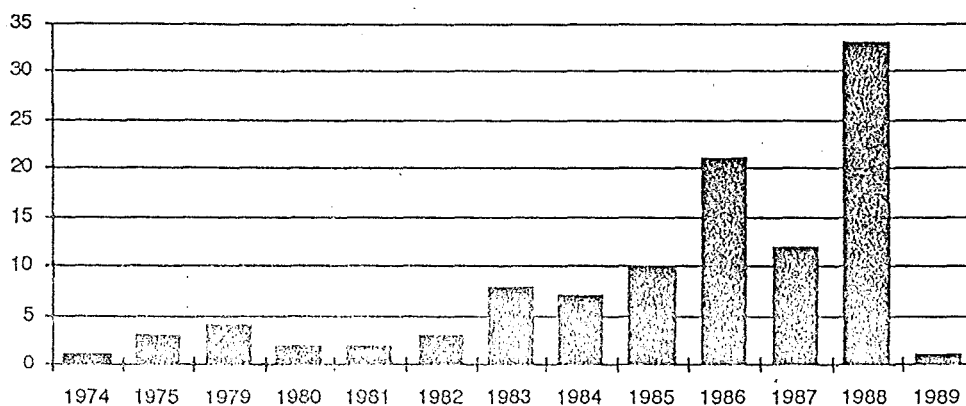
Social and cultural habits as well as the varying soil types all affect latrine design and the choice of technology. There is not a single model for excreta disposal that will be suitable for all cases in the musseques.

Of the 70% of households identified in the project area which already have latrines, almost half of them presented a serious threat to public health by overflowing, leaking into public thoroughfares or being blocked. Simple technological improvements can be presented to resolve many of these problems. Of the 30% of households not having latrines, most were aware of their importance but because this same 30% also roughly represents those living in rental accommodation, often the poorest, in the worst physical conditions. Not being house owners, these residents are reluctant or lack sufficient resources to invest in upgrading their sanitary conditions by constructing latrines. The problem of sanitary improvement therefore can not be resolved by simple technical improvements, and has an important social and economic dimension. The project therefore proposes a programme of community health development in parallel with appropriate technological inputs.

Accumulated solid waste is a major public health problem: it sustains large populations of flies and rats; children cut themselves when they are scavenging and are susceptible to tetanus and other infections. All these dangers are compounded by the practice of defecating on rubbish heaps in the absence of access to latrines. Following the study "Emergency Sanitation for Luanda's Musseques" the proposal for solid waste removal supported burning and burying. (A solution which is also supported by the community). The City Council insisted that their policy only allowed removal of rubbish by containers and lorries. Unfortunately, many of the musseques streets are inaccessible to the size of lorries required and the City Council does not have the disposable funds to install the required containers in accessible areas in Ngola Kiluanje. The current population of Ngola Kiluanje, approximately 60,000 people, produces approximately 24 MT of solid waste per day or about 2400 cubic meters per month. The project area therefore requires at least twenty of the 12 cubic meter containers currently used by ELISAL and a schedule of 10 pickups per container per month, probably also demanding the full time work of at least one truck and driver to remove rubbish to the city dumping site.

Such a system would require the full-time cooperation of the community and coordination of project activists to ensure that the official rubbish deposits are respected and the informal ones constantly cleaned and eventually eliminated. A massive one-time campaign involving ELISAL, the Project and the community would have to be organized over several weeks to clear the backlog of rubbish which has accumulated on some sites over several years. This plan would also involve repositing rubbish in designated landfill sites within the project area as an anti-erosion measure. The upgrading of some access routes by depositing earthfill and the improvement of drainage will be necessary to ensure that ELISAL trucks maintain access to the rubbish deposits in the rainy season.

Data de Construção das Latrinas
Construction Date of Latrines



4.0 COMMUNITY BASED STRUCTURES

4.1 Policy

Right after independence, the MPLA party designated the popularly-based organizations of workers, women and youth as the main vehicles through which people would organize locally. There were also early policies emphasizing People's Power at the local level. In many musseques, cells were formed by local residents. But these structures were later disbanded by the government as a result of internal political tensions within the party during the post-1977 period.

Subsequently residents' committees were organized in many of the musseques to replace the Peoples' Power groups. But most of these committees are presently inactive, as they have little power in comparison to their earlier grassroots predecessors.

During 1990-91, the Angolan Government adopted a policy of wide ranging reforms with the aim of increasing democratization leading to a ceasefire and future free elections. One of the first indications of this broadening political liberalization was the introduction of the law on "associations", under which national non-governmental organizations and political parties were allowed to form.

4.2 Structure

4.2.1 Residents' and Other Committees

At the local level, each commune is divided into sectors and the sectors are divided into blocks (called quarteiroes). Whereas the commissioner at the commune level is a political appointment by central authorities, the sector and block coordinators are elected; sector coordinators work under the jurisdiction of the commune commissioner's office.

In theory, regular meetings are held in each block at which residents can discuss their problems and concerns; regular meetings also occur between the sector coordinator and the block coordinators.

Also in theory, each sector is organized into one (elected) Residents' Committee, which meets monthly with the sector coordinator. The Residents' Committee works mainly with the BPV (People's Vigilance Brigade) and OMA (Angolan Women's Organization) to mobilize residents to participate in activities such as public clean-up campaigns.

Some schools have Parents' Committees. These provide a vehicle for parents of schoolchildren to be involved in school activities such as clean-up campaigns inside and around the school building. Many of these Parents' Committees, however, are inactive:

parents say they are too busy and have no time to attend meetings. It has also been difficult to try to mobilize parents through the Residents' Committees, as the latter does not link with the schools.

4.2.2 Community-Based Organizations

As a result of the broadening political liberalization taking place in Angola, many new Angolan NGOs, CBOs (community-based organizations) and civic and environmental associations have been forming and have begun registering. Some of these new organizations have formed themselves around themes, e.g., the environment, hunger and famine, health issues, civic rights, etc. These new groups are tapping a new form of voluntarism in their constituencies, a voluntarism drawing on personal interest and commitment rather than party affiliation.

In May 1991, Angolan NGOs (and some CBOs) formed their own umbrella organization. Called FONGA (Forum of Angolan NGOs), the objective of this group is to provide an opportunity for national NGOs to exchange opinions and identify ways to solve common problems.

4.2.3 Churches

Angolan church organizations are the one NGO structure which, at the local level, has to date been able to undertake small-scale development structures. It is significant that it is from the churches that many of the new Angolan NGO's have evolved.

Many churches at the local level have a range of associated groups, e.g., Women's Clubs, Men's Clubs, Church Youth, etc. In addition, some churches provide private health and/or educational opportunities for musseque residents.

4.2.4 Private Sector

Throughout Luanda's musseques, small-scale enterprises (SSEs) are the basis of survival for many residents. Even for those who work in the formal sector, SSEs often provide alternative sources of income for the household economy.

Based on a 1991 DW study of SSEs in Ngola Kiluanje, the following observations can be made:

- SSEs are often well organized, although working conditions are frequently poor for both adults and children
- SSEs generally buy everything they need on the parallel market, which is often a problem because of speculative prices and the frequent unavailability of necessary materials
- SSEs are frequently located on the premises of the owner, with the space often being inadequate for the activity which is being carried out
- the frequent lack of energy, lack of water and general lack of capital is a serious problem for the expansion of SSE activity.

4.3 Functional Analysis

At the musseque level, the first post which can be said to be truly "representational" is that of sector and block coordinators, as these are elected positions. One problem which has made these structures weak, however, has been the lack of a clear articulation between formal and informal structures. For example, there is no clearly defined relationship between residents' committees and formal state structures, even at the commune level. As a result, these structures are unable to function effectively as they lack formal linkages with government structures.

More recently, there is more willingness to discuss local issues in the musseques, where grassroots politics is now of growing importance and where local structures are starting to discuss ways of cooperating with service providers in improving local services and environment. Civic institutions, however, are still few in number and there has not yet been the development of ground rules of civic responsibility and mechanisms of control by the community.

The new informal groups (NGOs and CBOs) are genuinely popularly-based, locally-inspired and represent local needs, perceptions and community-based attempts to solve problems. However, they are also fragile; most have few paid staff, limited resources (human, material and financial) and often rely on voluntary work to carry out their programmes. In most cases, they have little or no experience in project identification, implementation and evaluation. Many of their efforts are still directed towards establishing their own constituency bases. Even so, since late 1990 when these local groups began to emerge, it has been found possible for foreign NGOs to work more directly with the community through these national partners.

4.3.1 Ngola Kiluange - Project Area

A group of seven activists work six mornings a week on the Sambizanga Project and are paid by the project. In 1990-91, all seven - some of whom have been trained previously - did an intensive 5-week basic first aid training programme in collaboration with the Angolan Red Cross followed by on-the-job training. There are also about 40 voluntary activists who work at least one morning per week on the project. • started off #s.

Both groups of activists come from the project area; the majority have completed sixth class and a significant number have completed eighth class. (Eighth class is the entry requirement for pre-university). Most are young, between 18-20 years old. The youngest is 16 years old. Of the 42 voluntary activists, 18 are women.

In selecting permanent activists, the project gives a priority to women. Recruitment is also based on sector (of residence) to ensure that all areas of the project are represented among the

activistas.

✓ The primary activities of the permanent activists include a range of support activities to the health centre, e.g., vaccination, baby weighing, assistance in dressings, a Health Education Talk given each morning in the health centre and house to house visits once each week in the community. Some activists spend more time on activities more directly related to community development, e.g., community-level and public service organising of rubbish disposal, preparation of the community for an improved water network and organising collaboration between the community and the public water company to effect these improvements in water distribution.

only voluntary ones?
The voluntary project activists are also members of a new community-based organisation which grew out of the project's work around tree planting and a school poster contest on the theme of garbage / community cleanliness. In June 1991, some youth from Ngola Kiluanje met with the coordinator of the project to find out what was happening. They liked the work being done, and two weeks later decided to form a new association of youth in Ngola Kiluanje called the Associacao de Amigos de Ambiente (AAA or Association of Friends of the Environment). Receiving assistance from the project in their initial setting-up phase, AAA members have now grafted themselves on to the project structure looking for support in planning and implementation of their activities. To date, the energies of AAA have been directed towards tree-planting (the plan is to plant 100 mainly shade trees each month) garbage cleanup campaigns, developing and maintaining a sustainable rubbish disposal strategy, and painting of public buildings such as schools and health units.

Soon after beginning their cleanup campaigns, AAA realized that unilaterally cleaning up problem areas without any active participation from the people who had put the rubbish there in the first place was not a successful strategy for the long term. Hence the development of the idea of community education via house-to-house visits. These visits initially concentrated on rubbish disposal but the nature of the issue led to a consideration of water and latrines, which led directly into health issues. By August 1991, the activists had visited 4,133 houses in four sectors of Ngola Kiluanje: San Jose, Sao Pedro de Barre, Vale Saroca and Central. These house visits have already motivate residents to participate in campaigns, e.g., already there are more parents bringing their unvaccinated children into the health centre.

In November 1991, the activists also carried out a vaccination campaign in Vale Saroca, where it is estimated that 75% of the local population is unvaccinated. The activists say the reasons for the high level of unvaccinated people are:

- the greater distance of this sector from the health centre
- the high number of newly arrived immigrants (formerly displaced by the war) into this sector who are still unaware of the health centre and its programmes

■ the feeling of many residents from Vale Saroca that they will not receive treatment at the health centre

The results of this vaccination campaign were successful: 250 people were vaccinated (of whom 35 were new babies); over 200 others came to be vaccinated but there was insufficient serum to cover everyone. Activistas prepared for this campaign by carrying out a house-to-house mobilization two weeks earlier.

Hence the project has found itself with a group of potential community organisers who have selected the following areas for priority activities: rubbish disposal, water, sanitation and health education.

The very existence of the project has been a stimulus to the community. In August 1991, for example, about 50 youths from Sao Pedro de Barra - inspired by what AAA is doing - did a neighbourhood cleanup of six garbage areas. They and other youth from the musseque want to participate in AAA and in the project in the future.

There are also youth from other areas who want to do similar things. For example, one youth group from Rangel municipality contacted AAA and the Sambizanga Project to learn more about their activities. There is also a youth group in Bairro Operario (Sambizanga) and another in Sao Paulo who want to do similar things like cleanup campaigns. The Sambizanga municipal governor has also expressed interest that AAA and the Sambizanga Project expand to the entire municipality.

5.0 MATERIAL AND HUMAN RESOURCE ANALYSIS

The three potential resources for the project are: DW, the government and the community.

RESOURCES

STRENGTHS

POTENTIAL PROBLEMS

DEVELOPMENT WORKSHOP

- | | | |
|---|---|--|
| <ul style="list-style-type: none">-in-country experience in water, sanitation, urban planning and community development-team of in-country technical expertise backed by resource pool of international experts-training facilities for appropriate sanitation technology-local admin support-transport and logistical capacity-established network of donor support | <ul style="list-style-type: none">-established working relationships with national and community structures, both formal and informal | <ul style="list-style-type: none">-difficulty of long-term financial planning in a rapidly changing economic environment-conflicting expectations of different donors |
|---|---|--|

NATIONAL LEVEL GOVERNMENT

- | | | |
|---|---|--|
| <ul style="list-style-type: none">-admin support from DNSP and DNA-technical support from national health programmes, e.g., EPI (=PAV) | <ul style="list-style-type: none">-existing infrastructure-access to state funding | <ul style="list-style-type: none">-lack of urban development and land tenure policies-lack of professionally trained cadres with appropriate experience-inefficient delivery systems-poor intersectoral collaboration-lack of raw materials-budgetary constraints |
|---|---|--|

LOCAL LEVEL GOVERNMENT

- information of local conditions
- local experience
- awareness of problems at the community level
- recognized government representation at the local level
- little authority in central planning and decision making
- limited access to state resources

COMMUNITY

- community-based organizations
 - churches
 - private sector
 - household financial contributions
 - local labour
 - emerging community motivation
 - capacity to mobilize local resources
 - familiar with the project
 - no formal functioning linkage between community level and government administrative structures
 - lack of access to state resources and social services
 - reluctance to invest in community and household improvements because of legal insecurity and lack of land tenure policy
 - potential for social unrest depending on the impact of structural adjustment, unemployment and political developments
- Area-based orgs*

6.0 ENVIRONMENTAL IMPACT ASSESSMENT

6.1 The Physical Environment Analysis of the Project Site

- natural resource analysis
- climatic factors
- access to water
- access to agricultural land
- soil conditions
- natural vegetation

6.2 Impact of the Population on the Land

- land use patterns
- waste disposal
- erosion
- domestic fuel consumption

6.3 Impact of Local Industrial Development

- especially with reference to the interface between industrial and residential factors
- toxic wastes
- pollution - air, water & noise

6.4 Impact of Transport Network

- through-bairro movement
- local circulation

6.5 Settlement Pattern Morphology

- patterns and trends of urban growth

6.6 Legal Aspects of Environment and Land Use Policy

6.7 Environmental Degradation

6.8 Environmental Improvement

3.2 HEALTH SECTOR

3.2.1 Policy

The National Health System was established by law in 1975 in Angola. The guiding principles are

- health is an individual right and is the responsibility of the state
- services should have an integrated character but give priority to preventive health services
- activities in the health sector should be effected through active participation with the organised community

The Economic Recovery Programme (PRE) 1989-90 outlined the overall objective in the health sector as an improvement in the indicators of the health status of the population by expanding the coverage and increasing the utilisation of indicated priority services. The immediate objectives were detailed as

- a reduction in the morbidity and mortality from measles, tetanus, acute diarrhoeal illnesses, malaria and acute respiratory tract infections in the under five year olds
- a reduction in morbidity related to pregnancy and in maternal mortality by improving ante-natal and obstetric care at the different levels in the system
- training of health personnel at superior and middle levels; to expand the training of community health workers and to do refresher courses for traditional midwives and basic level health personnel
- to re-open, equip and where indicated expand the existing physical structures which are underutilised or where the same structures are not functioning at the moment

The present project can not seriously approach questions of housing or physical resettlement before the land ownership issue is resolved at national level. For this reason the proposal deals primarily with physical upgrading of community infrastructure and the improvement of social services.

- ✓ The pilot project area occupies an administrative commune and adopts Sectoral divisions, integrating their elected coordinators as representatives in project meetings. Sector boundaries are employed for project planning purposes and are considered in the recruitment of staff and volunteer workers.

specific actions?

The project hopes by its adoption of a commune as a pilot project area, to strengthen the local government apparatus at this base level. In order for this level of government to be effective, the necessary resources will have to be allocated, or mechanisms set in place for income to be generated and retained at the community level. It is anticipated that in the process of political and administrative reform that the lines of communication and responsibility will be reversed, making local government a channel for voicing local concerns regarding access to services and basic infrastructure, rather than simply serving to represent state authority at the community level. The latter depends on parameters beyond the control of the project can not therefore be considered among the project's objectives.

authority.

A case in point was the Angolan Government's attempt to bypass some of these problems in the urban development sector by the creation of GARM with the political backing of a Senior Minister. GARM's authority as a coordinating office for national and provincial executing agencies in this sector was never accepted by the key local government departments. Despite political pressure from the top it was not able to fulfil its mandate.

A further example of the weak local government administration is the lack of coordination between sectors and departments, even within the same ministries. Sectoral lines of responsibility are not clearly defined. Conflict can therefore occur over the control of the limited resources and investments when they become available. In order to undertake any action, approvals are needed from a number of authorities with overlapping jurisdictions, normally resulting in long bureaucratic delays.

✓ The fact that local government does not have its own source of income - i.e., there is no basis for local property taxes or other revenue sources and the policy that all public revenues in any case must pass through the state treasury - means that there is little flexibility in planning. Financial resources are available to the provincial government only through the Plan for the provision of urban services. Municipal government essentially controls only enough money to pay their small staff and the Commune level has virtually no resources at their disposal.

Administrative reform is accepted by most people as long overdue. The reform is likely to result not only in a restructuring of local government along with a redefinition of sectoral responsibilities but also deal with the question of the distribution of decision making power to the appropriate levels of local government. Along with decision making power the actual control of resources - financial and technical - must be distributed as well. Introduction of a degree of cost recovery is also a concept under consideration. The introduction of local sources of revenue such as through property taxes or other types of levies can assist in empowering local government structures as long as the central government does not insist that these revenues must all pass through the state treasury as before.

The introduction of property taxes or other forms of local-level income generation can only be done in conjunction with land ownership legislation. A cadastral survey of existing plot divisions and claims to ownership rights is a part of this process. The granting of land tenure rights to residents in the musseque is likely to be the most significant factor in stimulating investment of private household income in housing and environmental improvements. Householders presently are reluctant to invest their family savings in their homes due to lack of security of ownership and the often stated official view that these zones are illegal or temporary at best.

salary payments and very small budgets for simple repairs are handled by the Municipal Delegate.

The Municipality of Sambizanga is divided into three Communes. An appointed Commissioner represents government authority at the Commune level, the lowest level of local administration. The Commune Commissioner has only a small office staff and in the urban areas no other sectoral delegates or representatives. The Commune Commissioner often is in charge of security at the local level and until recently also held a local Party position. Through his Party role he also provided linkages with local-level "popular organizations" such as the trade union UNTA, the woman's organization OMA, defence brigades BPV and the Party youth JMPLA.

The commune of Ngola Kiluanje in the Sambizanga Municipality corresponds to the project area. Ngola Kiluanje Commune is in turn divided into four Sectors. The Sector, normally containing 10-25,000 people, is an administrative division used for social service planning. The sector should support one health post, and for planning purposes primary school aged children should attend school within the boundaries of their sector. The sector normally has a Coordinator who is chosen by the residents of the area. The Coordinator is a position with no direct government authority beyond the informal status derived from the community. The Sector is further divided into Quarteiros which often have their own Coordinator who works as an assistant to the Sector Coordinator. The Block is the smallest division including 20-30 households who send family members to the Block Committee and participate in the selection of the Coordinator.

3.1.3 Functional Analysis

The fact that Luanda, the urban centre, is also Angola's capital means that the city accommodates all levels of government administration, from the national, through provincial and municipal to the commune level. Confusion in the lines of authority and responsibility invariably arise. The chronic weaknesses in the administration at all levels result in slowness in decision making and programme execution. The tendency naturally arises to short-cut the system in emergencies, further adding to the confusion. Because of the presence of the powerful central government authority in the city there is a constant temptation to involve themselves in what are essentially local issues, either by intervening directly or by bringing their political influence to bear. Often by ignoring or bypassing certain middle level government authorities alienation of this middle level can occur, eventually leading to lack of cooperation and even obstruction.

Luanda suffers acutely from this problem. In spite of the special powers given to the Provincial Governor, the provincial and municipal administrations are weak, lacking technicians and experienced staff of all kinds. Angola's limited number of skilled cadres are normally drawn to central government service where they are naturally accorded more responsibility and

3.1.2 Structure

Local government power is derived from the authority of the Presidents' Office. Provincial Governors are appointed by the President and have the rank of cabinet ministers in the Council of Ministers.

The pattern of authority follows a pyramid structure with both decision-making and resources flowing from the top to the base. The Province consists of a number of Municipalities which in the urban context can be considered Townships or Districts. Municipalities are composed of several Communes, previously known as Bairros or the equivalent of urban Wards. Communes are in turn divided into Sectors and further into Quarteiros and Blocos.

- o Provincial power rests with the Provincial Governor, a political appointment, who is assisted by Vice-Governors for key sectors; technical matters, social affairs and community services. Most of the service-providing ministries and national departments have
- ? - Delegates and small staffs who work closely with one of the Vice Governors in their appropriate spheres. The Provincial Governors' Office of Planning is responsible for coordinating all budgets for provincial and lower level institutions, preparing proposals and channelling them to the central government authority for approval and financing.

The Provincial Government also manages Provincial Companies providing essential services such as water (EPAL) and sanitation services (ELISAL). State companies such as these have traditionally run at a loss, so for the time being depend on the same line of financing as other provincial institutions.

Municipal Governors or Commissioners are appointed as well by central authorities to preside over Luanda's nine Municipalities. The Municipality of Sambizanga, for example, has a population of over 200,000 people.

- o Municipal boundaries were drawn, wherever possible, to provide for a mix of land uses and include some urban core, business district, industry as well as musseque residential area.
- o The Municipal Governor also has Assistants who are responsible for technical matters and socio-economic affairs. Municipal Delegates represent only a few Ministries providing essential services, i.e., Education, Health, Social Services and Security. The Municipal Commissioner often also takes on the role of Commander of Municipal Security Forces and in the past, Municipal Party (MPLA) coordinator. Party roles have been formally dropped as part of the current civic reform process.

Municipal Government depends on the Provincial level for budgetary approval and indirectly on central authorities for all financing. Municipal Government has few staff or technical resources of their own, apart from a brigade of street cleaners and a small number of office workers. Schools and health posts falling within the municipal boundaries are administered by their respective sectoral Delegates of Education and Health. Only

anticipation of Angola's first multi-party elections in the second half of 1992. The results of this new ministry's work is likely to have a major influence on local government administration and its relationship with other levels of government.

Possibly the most important policy issue affecting urban development is the ownership and control of land. With independence the formal ownership of all land previously held in private hands passed to the state, although use and control of property generally remained with those who occupied it. Governmental decrees were used to confiscate abandoned properties but a formal system of laws has not been put in place to regulate these acquisitions.

Land use policy is assigned to the Ministry of Plan's Institute for Physical Planning (IPF). IPF is responsible for urban zoning and for approving all proposed projects including housing, industrial and commercial use of land. The Provincial Governor's technical office controls the actual distribution of plots of land. Lacking up-to-date cadastral surveys and the necessary technical staff to manage the process, the demand for building plots far outweighs the technical offices' capacity to approve, survey and register them. The government's lack of capacity to manage land has meant that forms of informal occupation are accepted by the majority of people, to the extent that unregistered buying and selling of property is common.

The government and all opposition political parties have recently adopted private ownership of land and other forms of property as their policy. Much legal and technical survey work needs to be carried out to make the new policy a reality. Several years of work will be necessary before the results of the new policy are felt or seen.

3.1 URBAN ADMINISTRATIVE SECTOR

3.1.1 Policy Considerations

Local government administrative policy has been characterised over the years by the tendency toward strong centralization with some notable recent attempts at limited decentralization. Angola inherited at independence a centrally controlled government structure from the Portuguese colonial power which itself lacked any democratic tradition. The Central Planning development model opted for after independence tended to reinforce this structure.

The Ministry of Plan until recently was the key national institution which controlled not only the direction of development policy but also all financing. The Angolan economy, being essentially fueled from the sale of petroleum on the international market, lends itself to centralized management. There has been no attempt to establish a tax base or to raise public funds locally. Lines of authority therefore quite naturally follow the lines of economic accountability. Financing of social services and urban infrastructure are all controlled at the national level of government. Annual planning proposals are drawn up by executing Ministries and local levels of government and presented to the Ministry of Plan for their approval and funding. The planning cycle is therefore fairly rigid. Little discretion is therefore offered to local government beyond that provided for in the annual plan to respond to emergencies or new initiatives that occurred outside of the planning cycle.

Appointments to positions in the administration have been made by the central authority. Lines of responsibility and decision making therefore follow the top-down command structure.

Several attempts were made to overcome inherent problems in Local Government administration. Early in the 1980's a new ministry was set up to reinforce local-level government; the Ministry of Provincial Coordination. The initiative effectively gave provincial governments the status of departments of a single ministry therefore failing in its prime objective. Empowerment of provincial-level authority was subsequently achieved by giving Provincial Commissioners "cabinet" positions equivalent to Ministers and making them the personal representatives of the Head of State. Further strengthening of the Provincial Commissioner's rank was achieved later in the decade by making provincial-level ministry (Delegate) appointments the responsibility of the Provincial Commissioner rather than the Minister in the capital. Finally the 1991 decree which gave the Provincial Commissioner the previous colonial title of Governor had more than symbolic significance in strengthening the image of provincial authority.

The recently created Ministry of Territorial Administration has as one of its important mandates the strengthening of civic institutions and the creation of democratic legal structures in

the musseques. This office was accountable directly to the "Super Minister" of the Productive Sphere. (Super Ministries, a feature of government in the mid-eighties, represented an effort to unblock sluggish administrations and channel and coordinate intersectoral activities). The policy intention was that GARM, in the face of an overwhelming problem, would initiate small pilot projects in the musseques which would involve community participation and joint action by various government services. These projects were intended to provide experiences for future planning in the sector. In reality GARM achieved little: on the one hand, it had little success in establishing a working relationship with the community and on the other hand it had no success whatsoever in persuading government departments to become involved in any process of urban upgrading, no matter how limited. In addition the government budget promised for GARM's activities did not materialise and concomitantly the offices of Super Ministers were abolished. Effectively, GARM had ceased to exist by 1990 and its staff was transferred elsewhere. This 1986 policy initiative was neither continued nor replaced. Today, there is no specific central government department with any particular responsibility for development in the musseques. At local government level, the Municipal and Communal Commisaires continue to have local responsibility for policy implementation; but these offices have a limited budget, poorly trained staff and no possible access to central decision making apparatus. To-date, there is a recognition that the populations in the musseques do have a right to a minimal level of functioning public services but there have not yet been policy decisions on how this should be achieved.

skill based idea?

work by these

3.0.2 The Realities of Urban Upgrading in the Current Policy Vacuum

Effectively, the government (and city council) continue to grapple with the problem of maintenance of the infrastructure inherited from the colonial period: the priorities continue to be water and waste disposal but realistic expectations are to service effectively the areas of "the cement city". At least two thirds of Luanda's population lives outside this formal urban sector in the mushrooming bairros. Essentially, immediate improvements in the services they receive will only be effected through community demands and subsequent piecemeal negotiations with individual service providers. This is particularly true in the areas of water, sanitation and rubbish disposal: the health and education sectors do aim at a minimum service coverage for defined population catchments. The quality of service nationally in these sectors suffers from the same problems as all sectors in Angola: lack of qualified personnel, poor staff morale and high absentee rates caused by low salaries and difficult work conditions, budgetary constraints, weak professional training, ill-defined career structures and more recently and as a consequence of the preceding, labour unrest. The impact of these constraints is even more evident in deprived peri-urban areas where constructive supervision is virtually non-existent.

* demonstrate local ^{community} awareness of pr. (ACBSO's?) can mobilise to implement H₂O or SAN?