

Approved by the Executive Board
5 February 2009

United Nations Children's Fund
Executive Board

Revised country programme document

Angola (2009-2013)

The draft country programme document (CPD) for Angola (E/ICEF/2008/P/L.18) was presented to the Executive Board for discussion and comments at its second regular session of 2008 (15-18 September). The Executive Board approved the aggregate indicative budget of \$34,500,500 from regular resources, subject to the availability of funds, and \$122,000,000 in other resources, subject to the availability of specific-purpose contributions, for the period 2009 to 2013.

In accordance with Executive Board decision 2006/19, the present document was revised and posted on the UNICEF website no later than six weeks after discussion of the CPD at the second regular session. The revised CPD was approved by the Executive Board at its first regular session of 2009.

<i>Basic data</i> [†] (2006, unless otherwise stated)	
Child population (millions, under 18 years)	8.8
U5MR (per 1,000 live births)	260
Underweight (% , moderate and severe, 2001)	31
Maternal mortality ratio (per 100,000 live births, 2005)*	1 400
Primary school enrolment (% net, male/female, 2001)	58/59
Primary schoolchildren reaching grade 5 (% , 2001)	75
Use of improved drinking water sources (% , 2004)	53
Use of improved sanitation facilities (% , 2004)	31
Adult HIV prevalence rate (% , 2005)	3.7
Child work (% , children 5 to 14 years old, 2001)	24
GNI per capita (US\$)	1 980
One-year-olds immunized against DPT3 (%)	44
One-year-olds immunized against measles (%)	48

[†] More comprehensive country data on children and women are available at <http://www.unicef.org/>.

* This figure is a 2005 estimate developed by WHO/UNICEF/UNFPA and the World Bank, which is adjusted for underreporting and misclassification of maternal deaths.

The situation of children and women

1. Angola has an estimated population of 16.6 million, of which 60 per cent are less than 18 years old and 66 per cent are living in urban areas. The country suffered from a prolonged war that prevented development, damaged infrastructure and left many Angolans across the 18 provinces in isolation and poverty. Despite a booming national economy and government efforts to develop infrastructure, Angola still ranks 162nd on the Human Development Index, and the United Nations still has a strong role to play in capacity development and technical assistance. Since the war ended in 2002, inflation has steadily decreased and the economy has started to grow, largely fuelled by the oil sector. The gross domestic product per capita in 2006 was \$2,547, but income is extremely unequally distributed, with a large share of the population below the \$2 a day poverty line.

2. Angola signed the Convention on the Rights of the Child in 1990, the Convention on the Elimination of All Forms of Discrimination against Women in 1986, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights in 1992, the chapter of the Protocol of the African Charter of Human and People's Rights related to women's rights in 2007. Key recommendations of the Committee on the Rights of the Child in October 2004 included the establishment of a national council for children and strengthening the monitoring and statistical system on children's rights. The National Council for Children (CNAC) was established in 2007, together with the adoption of 11 Commitments¹ to Children to

¹ The 11 Commitments to Children are in the following areas: (1) Life expectancy; (2) Food and nutritional security; (3) Birth registration; (4) Early childhood education; (5) Primary education; (6) Justice for children; (7) Prevention and reduction of the impact of HIV/AIDS on the family and children; (8) Prevention and mitigation of violence against children; (9) Family capacity;

be implemented, coordinated and monitored by CNAC. These Commitments are based on the Millennium Development Goals and the Convention, forming a strong framework for realizing children's rights.

3. The Government has increased allocations to health, from \$1 billion in 2007 to more than \$2.5 billion in 2008. However, that government investment favours hospital care, as 40 per cent of public spending on health goes to tertiary care; only 27 per cent are allocated to primary and secondary treatment and care. Access to basic health care is also limited by the persistence of vertical approaches and absorption and implementation constraints. Greater investment in basic services since the end of the civil war should have a positive impact on public health in the medium term, but official figures, based on 2001 data, still show an under-five mortality rate of 260 per 1,000 live births and an infant mortality rate of 154 per 1,000 live births, amongst the worst in the world, with even higher rates in underserved parts of the country. The main causes of child deaths are diarrhoea, acute respiratory infections and malaria, with malnutrition an underlying cause. Child malnutrition is widespread, with almost one third of children under five being underweight. The escalation of food prices is likely to worsen this situation. The maternal mortality ratio is high, estimated at 1,400 per 100,000 live births, largely due to anaemia and unsafe delivery practices. Child immunization rates are low, due to capacity gaps in service delivery systems, over-reliance during the post-conflict period on campaigns and uncertainties over basic demographics, making planning and delivery difficult. Despite some success on reducing the incidence of measles, tetanus prevalence remains high, and Angola remains one of the few countries where polio has not been eradicated.

4. The high mortality and morbidity of children are closely related to waterborne diseases. Although Angola has made significant progress in increasing its drinking water coverage since 1996, about half the population still relies on unsafe drinking water. Less than 10 per cent of schools have in-house water, less than 31 per cent of people use an improved sanitation facility, and poor hygiene knowledge and practices are common. Recent government policy decisions to provide water for all and to create a department to specifically address sanitation provide a historic opportunity for the right to water and sanitation.

5. The national prevalence of HIV and AIDS is now 3.7 per cent, and the disease is no longer confined to specific high-risk groups or areas. The impact on children will be increasingly serious, and more attention and resources will be needed on care and support in addition to prevention interventions.

6. As a result of increased government funding, from \$1 billion in 2005 to more than \$2.6 in 2008, primary school enrolment has increased in recent years, with net enrolment rising to 49 per cent in 2002, and gender parity in primary school attendance. However, drop-out and repetition rates remain high, at 15 per cent and 29.4 per cent, respectively. Completion rates were only 33.2 per cent for primary education.

7. The child protection sector is facing a transitional phase, with some issues (family reunification, mine risk education) fading in importance since the end of the conflict, while other issues (violence, orphans, access to justice, birth registration) are receiving increased attention.

(10) Children and the media; (11) Children and the state budget.

8. A general lack of recent valid, reliable, disaggregated data constrains analysis, planning and implementation of development programmes across all sectors.

Key results and lessons learned from previous cooperation, 2005-2008

Key results achieved

9. Progress was made on improved and new policies and on other programmatic planned results, but the outcomes and impact on children and women are difficult to measure due to the paucity of data. To address this, updated, key disaggregated data for 2008 is currently being collected through a joint survey (combining a multiple indicator cluster survey [MICS] and a household income and expenditure survey) as well as an Angolan Child Survival and Development (ACSD) baseline study.

10. At the policy level, UNICEF supported the Government in its efforts to revitalize health services in five provinces, covering 26 per cent of the population. The revitalisation and ACSD strategy supports the country's decentralization policy by strengthening capacities at the municipal level to provide high-impact, low-cost interventions. Some 50 per cent of target municipalities have developed budgeted multi-year plans. Additionally, the use of community health workers was introduced in Luanda province, and 1,885 agents were trained. This approach is being expanded by the Ministry of Health in all 18 provinces of Angola.

11. Major policy accomplishments in ACSD include finalization of the National Strategic Plan on Reduction of Infant and Maternal Mortality; the signing of a Memorandum of Understanding with the United Nations Population Fund and the World Health Organization to support the Government in reaching the Millennium Development Goal targets; and finalization of the joint ACSD investment plan for Angola. Technical support was provided to the Ministry of Health in developing the national roadmap for accelerated reduction of maternal and neonatal mortality, including a national emergency obstetric and neonatal care survey that led to the development of a national policy on emergency obstetric care. UNICEF also supported the introduction of maternal death audits in all municipalities in the province of Luanda.

12. Since 2005, 13 national polio and vitamin A campaigns have reached over 5.3 million children under five in each round. A national measles 'plus' integrated campaign ('*Viva Vida com Saude*' – "Live a Healthy Life"), combining the provision of measles and polio vaccines and other medicines and supplements ('plus') with the distribution of insecticide-treated mosquito nets, was held in 2006, reaching 3.8 million children under five. A national plan for elimination of maternal and neonatal tetanus was launched in 2008, targeting 3.8 million women of childbearing age. For routine immunization, cold chain supplies and training were provided.

13. The programme of cooperation also supported the National Malaria Control Strategic Plan, aiming at a 60-per cent reduction of malaria by 2012. Since 2005, UNICEF has supported the distribution of 1.86 million long-lasting insecticide-treated mosquito nets to pregnant women and children under five; provided technical assistance on management and monitoring systems; carried out routine training of health workers and community mobilizers; and supported micro-planning for health commodity distribution.

14. Programme advocacy led to protocols in support of exclusive breastfeeding, which is also promoted through the Baby-Friendly Hospital Initiative. Salt iodization was promoted. Under the framework of ACSD, milk was provided in therapeutic feeding centres throughout the country; health workers in hospital paediatric wards were trained in the management of malnutrition; and community management of severe malnutrition was introduced. Research on food prices is being undertaken, towards the development of a Joint Plan of Action on the impact of increasing food prices on children.

15. UNICEF responded to cholera and flood emergencies by providing safe water and sanitation facilities, mobilizing communities to prevent the spread of disease, providing information and supporting patient treatment, where needed. Partners' capacity to plan for emergencies was strengthened.

16. A national management information system was established to map all water points in the country. In its advocacy efforts, UNICEF encouraged the Ministry of Environment and Urban Planning to coordinate sanitation policy with sanitation awareness activities, such as the "International Year for Sanitation", leading to the first national sanitation workshop and a memorandum of understanding for sanitation improvement.

17. The enactment of a 'Water for All' bill and a joint United Nations initiative on water management, including consultations with government partners at different levels, provided opportunities to complete provincial plans of action, which will become blueprints for provincial development plans.

18. Partnerships with the National HIV and AIDS Institute and the Ministry of Youth and Sports demonstrated the power of sports as a medium for raising awareness among out-of-school adolescents as well as those attending school. Results from the integrated approach included a life skills manual that covered key psychosocial life skills, education on gender, HIV and AIDS, and communication skills. The country programme supported a national communication strategy to operationalize the prevention component of the national AIDS plan. The Youth in their Free Time initiative targeting out-of-school youth was expanded to 10 provinces and 470 gender-sensitive HIV clubs in secondary schools.

19. Through a rapid expansion of services, 6.5 per cent of estimated HIV-positive pregnant women in Angola received antiretroviral prophylaxis for prevention of mother-to-child transmission of HIV. Guidelines on feeding HIV-exposed infants were finalized and disseminated. Antiretroviral treatment for children are presently available in all the 27 hospitals nationwide, compared to only 2 in 2005.

20. **Education sector.** The Ministry of Education drafted a five-year strategic plan, covering all areas from early childhood development (ECD) to tertiary education. A national framework for teacher training was developed, and 20,000 grade 1 teachers were trained. A national accelerated learning programme reaching out-of-school adolescents complemented life skills programming for youth, scaled up through new partnerships with churches and youth councils.

21. The school construction increased through the Schools for Africa Initiative, providing 88,830 children in 17 provinces access to education. School construction in undeserved vulnerable rural and peri-urban zones remains an absolute priority for communities in the context of continued post conflict reconstruction and is an invaluable tool in strengthening relationships and opening doors to policy debates in

education at all levels. Deworming campaigns in schools improved health of pupils. Early childhood development is still a new concept in Angola; however, the Ministry of Social Affairs strengthened community mobilization and began replicating a low-cost mobile ECD model. Some 120 national trainers from all 18 provinces as well as provincial heads of ECD sections were trained. A national rapid assessment on gender disparity in schools provided crucial information for developing protocols to address gender issues that prevented girls from completing school. Mine risk education was supported through non-governmental organizations (NGOs) in five provinces; however, given the now mature capacity of the Government, an exit plan was agreed upon.

22. **Child protection.** In 2007, a birth registration decree led to free registration for children under five years of age (implementation started in key provinces). Other results included communities' capacity strengthening for care and support to orphans and vulnerable children, support for legal reform, family reunification and social reintegration of children separated by war, and capacity strengthening for law enforcement officers on child-related issues. UNICEF also contributed to the debate on social protection for the most vulnerable children, and social protection became the cornerstone of the five-year strategy for the Ministry of Social Affairs. Assistance was provided to ensure that good-quality reports from the Government were prepared for the *A World Fit for Children* and *Africa Fit for Children*. New partnerships were reinforced through dialogue with the Government and provincial authorities on orphan policy, trafficking and sexual exploitation.

23. UNICEF-supported child protection networks were established in 12 provinces. Sixty representatives of provincial and national directorates of National Institute for the Angolan Child and the Ministry of Social Reinsertion, as well as members of civil society organizations, were trained on institutionalizing the networks; reinforcing birth registration; child-to-child radio programmes; and vocational training.

Lessons learned

24. Nationwide interventions, including massive immunization campaigns and distribution of insecticide-treated mosquito nets, have significantly improved coverage and access to basic social services. On the other hand, these have in some cases been detrimental to routine systems, particularly routine immunization coverage, which has declined. The Viva Vida Campaign demonstrated that health-related service integration could be undertaken successfully, and at scale; it also showed that geographical convergence of health-related interventions reaches large numbers of vulnerable children and families. Some limited scale operational programmes (school construction) are still required to prove validity of standards or methodologies. UNICEF field offices proved crucial in this accomplishment.

25. Work at national policy level led to laws and decrees on water, birth registration, justice for children; now the emphasis must be on implementing these policies at national, provincial, municipality and community levels. The decentralization programmes launched by the Government in 40 per cent of the 164 municipalities require technical assistance to strengthen capacity in subnational planning. In the current programme, \$1 million of UNICEF resources on water was being matched by \$10 million from the Government. To leverage additional government resources for approaches that can dramatically decrease child and

maternal mortality, rigorous operational research designs and impact evaluations are needed to provide compelling evidence for the most cost-effective approaches.

26. However, the collection, analysis, monitoring and evaluation of data need to be strengthened across all sectors, at both national and subnational levels. The lack of valid and reliable baseline and monitoring data, at both macro and disaggregated levels, is a major impediment to programme design, target-setting, monitoring and evaluation.

27. Despite a high gross national product, there are major disparities in Angola, caused by capacity gaps. Yet, relative to the Government and the national budget, the United Nations is a very small player. Therefore, to make a difference in capacity strengthening, harmonization and coordination of efforts among all development partners is essential. Pilot initiatives (related to justice, HIV and the Millennium Development Goal funds) are leading the way towards greater integration of programmes, supported by different partners. Additionally, UNICEF has also been able to partner with some private-sector organizations.

The country programme, 2009-2013

Summary budget table

<i>Programme</i>	<i>In United States dollars</i>		
	<i>Regular resources</i>	<i>Other resources</i>	<i>Total</i>
Child survival and development	17 213 500	64 715 000	81 928 500
Social policy and child protection	7 245 000	21 960 000	29 205 000
Education and youth	4 695 000	18 300 000	22 995 000
Planning, field, communication, external relations	1 897 000	4 064 000	5 961 000
Cross-sectoral costs	3 450 000	12 961 000	16 411 000
Total	34 500 500	122 000 000	156 500 500

Note: Additional funds for emergency response will be raised if and when necessary.

Preparation process

28. The previous four-year United Nations Development Assistance Framework (UNDAF) and UNICEF country programme were harmonized with the Government's development plan. The Government prepared a situation analysis as part of its review exercise, and the United Nations conducted a consultative, human rights-based capacity gap analysis. More in-depth situation analysis is pending publication of survey findings. A UNICEF midterm review, an UNDAF joint strategic review and sectoral strategy meetings all provided evidence for programmatic and management adjustments in the new country programme. The proposed country programme of cooperation is designed to support the UNDAF; it has already been endorsed by the Government, with the UNDAF validated separately at a strategic meeting chaired by the Ministry of National Planning.

Goals, key results and strategies

29. The country programme will support the Government in implementing its Five-Year Strategic Plan (2009-2013), with a particular focus on the 11 Commitments to Children. The overall country programme goal is to reduce disparities in the well-being of children by ensuring that vulnerable children in the most disadvantaged families and communities progressively realize their rights to survival, development, protection and participation. The country programme will contribute to a reduction in child vulnerability and an enhancement of child participation at national, subnational and community levels by influencing policy design and implementation, leveraging resources based on reliable data on child poverty and human development, and supporting scale-up of evidence-based integrated programmes.

30. Five strategic approaches underpin the programme: (a) support Commitment 1 (child survival) through a flagship programme, with policy and implementation strategies for the remaining Commitments established around this goal; (b) provide direct support to the Government decentralization programme by focusing on quality service delivery at the municipal level; (c) offer valued policy advice to the Government by combining rigorous, disaggregated data collection and analysis with convincing examples of best practices in the implementation of the Commitments at the municipal level; (d) enhance converging programme practice of all UNICEF sections within the same municipalities to ensure a holistic approach to achieving the Commitments; (e) develop a strengthened partnership with the National Council for Children for policy analysis, monitoring of programme implementation at the municipal level and recommendations for scaling-up good practices.

31. By the end of 2013, the programme will contribute to the targets of the 11 Commitments for Children and the Millennium Development Goal targets, including a 50-per cent reduction in child mortality, a 30-per cent reduction in maternal mortality, an increase in the net primary school enrolment rate to 90 per cent, as well as an increase in birth registration of children under the age of five to 80 per cent, and ensuring that all targets are covered by the State budget.

32. UNICEF will support partners to reach the following by 2013 in at least 16 target municipalities: (a) 80 per cent of pregnant women and children accessing an integrated package of essential maternal and child health, water and nutrition care; (b) 100 per cent of target municipalities have robust revitalization plans with budgets; (c) 30 per cent of children under the age of five are participating in an early childhood development programme or initiation classes; (d) increased number of children (to reach more than 90 per cent of the total number of primary school age children) are in certified child-friendly schools; (e) increased net enrolment rates to more than 90 per cent, reduced gender disparity by 80 per cent in enrolment and attendance, and improved retention to more than 90 per cent; (f) 100 per cent of municipalities have education plans with budgets that increase the allocation of resources to primary education; (g) sufficient places for second chance education provided to reach at least 50 per cent of the demand; (h) 75 per cent of HIV-positive mothers and children access PMTCT services; (i) the most vulnerable children identified and accessing social protection measures in 16 municipalities; (j) permanent birth registration facilities, with trained staff and resources, established in all target municipalities; (k) community-level child protection

networks providing children protection from violence, abuse, exploitation and neglect in 16 municipalities.

33. At the national level, UNICEF will contribute to further policy development in relation to gender and education, second chance education, access to early childhood education, social protection, alternative care for children, meeting the core commitments to children in emergency situations, and advocating measures to mitigate the impact on children of special risks, such as increasing food prices. UNICEF will also contribute to the development of the national indicator system for children (SICA) and to the strengthening of capacity to collect, collate and analyse data at the provincial level.

Relation to national priorities and the UNDAF

34. The programme was developed to support UNICEF commitments within the UNDAF and is consistent with the national development plan, building on the 11 Commitments for Children. The programme supports sectoral country-level strategic plans jointly developed with counterparts and partners, including the United Nations Joint Programme on HIV/AIDS, national plans for education, the national health policy and regular involvement from Ministry of Planning.

Relation to international priorities

35. The new country programme is guided by the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women and humanitarian principles, and follows a human rights-based approach to programming, focusing on capacity strengthening to ensure that the rights of children, especially the most vulnerable, are realized. The programme's planned results are fully aligned with the UNICEF medium-term strategic plan and will contribute to achieving the Millennium Development Goals. The country programme is also in harmony with the regional strategies of the African Union and the United Nations, and the recommendations of the international human rights bodies.

Programme components

36. **ACSD programme.** This programme will converge interventions in health, nutrition, water and sanitation, and PMTCT and paediatric AIDS to contribute to a 55-per cent reduction in both child and maternal mortality. Outcome will be in five areas: (a) improved policy frameworks for integrated child survival and maternal health; (b) strengthened capacities at national and subnational levels to plan, budget, manage and coordinate health systems for the reduction of maternal and child morbidity and mortality; (c) 75 per cent of women and children have access to quality health care services in the 16 selected ACSD municipalities; (d) 75 per cent of caregivers and communities have improved capacities in key family care practices in the 16 ACSD municipalities; and (e) the Angola database of indicators related to child survival and development is greatly enhanced with up-to-date, valid and reliable data, disaggregated by sex, age and other characteristics, which can be used for policy and programme advocacy and decisions.

37. The policy development, advocacy and partnership for child survival subcomponent of the ACSD programme will advocate for sufficient allocation of financial and human resources to child survival programming through: (a) support

for evidence-based advocacy for the scale-up of the revitalization of health services; (b) establishment of Government-led coordination mechanisms for child survival; and (c) advocacy to address bottlenecks to ensure that the most vulnerable women and children have access sustainable quality care. The MICS and income and expenditure survey, carried out by UNICEF, the World Bank and the Government of Angola, will be a vital contribution to a national database with disaggregated data, and the National Statistical Institute will be supported to upgrade administrative data collection.

38. The subcomponent on institutional capacity strengthening for decentralized planning and management of health services will provide technical support to provincial and municipal administrations as well as health teams in 16 selected municipalities, to ensure the development of budgeted integrated multi-year child survival plans. These plans will be the basis for leveraging resources for nationwide scale-up by the Government and other partners. This will include (a) capacity strengthening in participatory planning and budgeting to develop municipal multi-year budgeted plans for child survival within the context of the revitalization strategy; and (b) support for health management structures at all levels to ensure delivery of quality health care services.

39. The quality health care service delivery subcomponent will be divided into two key result areas: (a) revitalization of health services; and (b) nationwide emergency preparation and response. The former converges UNICEF child survival programmes in the 16 selected municipalities to provide an essential package of services, including (a) provision of supplies and training of health care workers in delivery of family planning, antenatal care 'plus'², expanded programme on immunization 'plus', and integrated management of childhood illness 'plus', nutrition, PMTCT 'plus' and paediatric AIDS; (b) water treatment and sanitation systems for health units and households; and (c) increasing access to birth registration. The second area will build capacity to deliver nationwide life-saving high-impact interventions and emergency response. This includes support to (a) national plans for polio eradication, measles mortality reduction and neonatal tetanus elimination; (b) biannual child health days for delivery of vitamin A and albendazole; (c) distribution of long-lasting insecticide-treated mosquito nets; (d) iodine deficiency disorders elimination, quality control and food fortification; (e) therapeutic feeding for children with severe malnutrition; and (f) emergency response.

40. The community development, behaviour change and social mobilization subcomponent will focus on strengthening capacity of communities and families to adopt key family care practices, through (a) establishment of a network of community agents in health areas to promote behaviour related to preventive health, nutrition and home-based care; (b) promotion of hygiene and hand washing with soap, appropriate sanitation, routine immunization and birth registration; and (c) strengthening the capacity of communities to manage resources and sustain action towards ensuring safe water use, appropriate sanitation and disposal of waste.

41. The monitoring and evaluation to strengthen evidence for the ACS D subcomponent will support the development of a child survival monitoring system

² The term 'plus' refers to the combination of services with other interventions, such as the distribution of insecticide-treated mosquito nets or vitamin A supplementation. These vary from case to case.

to measure progress and identify problems for appropriate action. This will include (a) supporting regular evaluations and peer reviews of the revitalization process; (b) establishing baseline data on social development indicators of ACSID interventions; (c) supporting implementation of household and health facility surveys; and (d) documenting and disseminating best practices and lessons learnt to feed into the advocacy for the government roll-out of the revitalization process.

42. **The social policy and child protection programme** will strengthen the capacity of the National Council for Children in policy-related analysis and dialogue, promoting vertical linkages between national and local levels and strengthening accountability in implementing the 11 Commitments. The cornerstone of the programme will be poverty reduction through policy and practice. It will include annual analysis of the national budget and budget execution, use of evidence-based advocacy and technical assistance to develop social protection policies and other policies, using data from the national indicator system for children (SICA). Strong linkages will be made with the decentralization process and with local capacities in planning and budgeting for the 11 Commitments. The development of SICA will require investment in administrative routine data-collection mechanisms and strategic surveys, to build DevInfo databases at the National Institute of Statistics and at provincial institutions.

43. The child protection component will aim to improve the protective environment in Angola, where children are protected from violence and exploitation, and where laws, services, behaviours and practices minimize the vulnerability of children, address known risk factors, and strengthen children's resilience. This human rights-based approach emphasizes prevention, participation of children and youth, as well as the accountability of government structures. Strategic actions include the continued domestication of the Convention on the Rights of the Child and the African Charter. The juvenile justice subcomponent will promote a common United Nations approach to justice for children based on the rule of law; disseminate knowledge on children in State and non-State justice systems and promote the legal empowerment of children and families.

44. The most vulnerable children care and protection subcomponent will reduce child poverty and vulnerability by implementing the Plan of Action for Most Vulnerable Children, supporting cash transfers and reducing barriers to free education and health services. The programme will engage NGOs, faith-based organizations, community-based organizations and families in the care, support and protection of the most vulnerable children. A strategy to prevent and mitigate violence against children will be adopted, mainstreamed and implemented in selected areas. Child protection networks will be further developed into community-based structures aimed at monitoring the implementation of the Convention on the Rights of the Child and 11 Commitments. The birth registration subcomponent will work within the framework of *Africa Fit for Children* of the African Union and the UNICEF global strategy to rapidly enhance enjoyment of this fundamental right.

45. The **education and youth programme** will include three subcomponents. The access to quality education subcomponent will include advocacy for inclusion of children out of school and for increasing equality in educational opportunities; creation of essential conditions for learning through technical assistance, to improve quality education and increase learning levels, including setting standards for school construction; improvement of education management at the school, municipal and

provincial levels, within the context of decentralization and increased budgetary allocations; support for an updated and accurate statistical system for monitoring education indicators.

46. The early childhood education subcomponent, will increase the number of children accessing community-based early learning activities, and will mobilize communities to implement proven models for sustainable early childhood education. The life skills and HIV prevention subcomponent will ensure that 80 per cent of school children between the ages of 13 and 15 and 50 per cent of the out-of-school children between the ages of 13 and 18 will be equipped with knowledge and skills to prevent HIV infection.

47. **Planning, monitoring, evaluation, communication for development and emergency coordination** will remain cross-cutting support areas for the Government and UNICEF programmes, with both operational and technical support at all levels.

48. **Cross-sectoral costs.** This component covers non-programme salaries, as well as travel and training. Costs will also include operational support to the country office administration and the provision of essential telecommunications equipment and for security support.

Major partnerships

49. The country programme will be implemented in cooperation with the Government of Angola, at the national, provincial and municipal levels, with United Nations agencies, NGOs and civil society (as part of National Council for Children), building on existing cooperation with community-based organizations, faith-based partners, media and civil society networks.

Monitoring, evaluation and programme management

50. The Ministry of Planning is the focal point for the coordination of the programme. The country programme results framework will form the basis for continued monitoring of development outputs and outcomes at the national level, in line with the UNDAF results matrix and an Integrated Monitoring and Evaluation Plan (IMEP). The IMEP will ensure that research, evaluations and surveys are strategically selected. Principles of results-based management will be applied. DevInfo will become the main tool for reporting progress towards programme results and towards achieving the Millennium Development Goals. Programme monitoring will include field visits, joint United Nations annual reviews of progress against annual plans, and a midterm review of programme results in concert with the UNDAF review.