Acknowledgements

The present report on the Situation of Children in Angola was prepared by the UNICEF Angola team with the support of a consultancy team from Oxford Policy Management (OPM).

The following UNICEF Angola staff participated in the preparation of the report and provided technical advice: Ana Patricia Silva (Child Protection Specialist), Clara Barona (Chief Programme Communication), Boukare Bonkongou (Health Manager), Domingos Chiconela (Chief Water and Environmental Sanitation), Edina Kozma (Chief Child Protection), Pieter Potter (Chief Education), Desire Adomou (Education Specialist), Jorge Trula (Social Policy Officer), Nelson Bernabe (Nutrition Project Officer), Renato Pinto (HIV and AIDS Manager), Vandana Agarwai (Nutrition Manager). Stefano Visani (Chief Social Policy) coordinated the process of analysis and report preparation and provided technical oversight for chapters 1, 2, 3 and 7.

Francisco Ferreira Songane (UNICEF Representative) and Amélia Russo de Sá (UNICEF Deputy Representative) provided overall supervision to the development of the SitAn and contributed with comments and recommendations to the different parts of the report.

A number of individuals from institutions based in Angola were consulted throughout the preparation of the report including the Office of the UN Resident Coordinator, other UN agencies in Angola, and non-governmental organisations (among which are: ADRA, Development Workshop, Rede de Luta contra a Pobreza Urbana de Luanda). Nelson Pestana and Aslak Orre from the Universidade Católica de Angola provided input on the subject of decentralisation. Throughout the preparation of the SitAn, the UNICEF staff consulted a number of their respective government counterparts’ officials and ensured that their views were reflected in the report.

Valuable comments and contributions were received also by the following UNICEF Eastern and Southern Africa Regional Office staff: Luwei Pearson, (Regional adviser Child Survival and Development), Peter Harvey (Regional Water and Sanitation adviser), Inge Vervloesem (Regional education specialist), Natalia Elena Wilder Rossi (Senior Social policy specialist).

Consultant Abigail Holman carried out a full editorial review of the English version of the report prior to translation.

Consultant Laura Alonso provided precious support to the final stages of the editorial review and printing of both English and Portuguese versions.

The translation of the report into Portuguese was done by Judite Balói.

The photographs in this report were taken by André Silva Pinto, Bruno Caratão, Germano Miele, José Silva Pinto, Vinicius Carvalho and Xavi Ximancas. Photographs may not be reproduced without express permission from UNICEF.
# Table of contents

Acknowledgements ................................. 5
List of figures, tables and boxes ................. 8
Abbreviations and acronyms ....................... 10
Foreword ............................................. 15
Executive Summary ................................ 17
1 Introduction ....................................... 27
   1.1 Objectives of the situation analysis .......... 27
   1.2 Methods and limitations .................... 28
   1.3 Conceptual framework ...................... 28
2 The country context ................................ 33
   2.1 Post-conflict economic boom: Angola as an upper middle-income oil producer 34
   2.2 Population and urbanization ................ 36
   2.3 Monetary poverty ................................ 37
   2.4 Rural vulnerability and climate change ..... 39
   2.5 Governance .................................... 41
   2.6 The legal and policy framework for child rights 42
3 Equity: To what extent is progress in social and economic development enjoyed by all? 45
   3.1 Comparing Angola’s performance to other upper middle-income countries in Sub-Saharan Africa 45
   3.2 Equity in key outcomes and access to basic social services 49
   3.3 Conclusions ................................... 53
4 Ensuring children’s survival and health ........ 55
   4.1 Child and maternal mortality ................ 55
   4.2 Child and maternal health care .............. 57
      4.2.1 Key interventions ....................... 57
      4.2.2 Supply-side bottlenecks: Infrastructure, human resources, and medicines 62
      4.2.3 Health behaviours and demand-side barriers to use of health services 65
   4.3 Child Malnutrition ............................. 68
      4.3.1 Under-nutrition and micronutrient deficiencies 68
      4.3.2 Scaling up an integrated package of nutrition interventions 72
   4.4 Children and HIV/AIDS ...................... 75
      4.4.1 Profile of the epidemic .................. 75
      4.4.2 The national response to HIV/AIDS: prevention, treatment and care 75
   4.5 Water, sanitation and hygiene ............... 79
4.5.1 Use of improved water sources and sanitation facilities
4.5.2 Hygiene practices
4.5.3 Policy challenges for extending and sustaining coverage

4.6 Summary of priority actions

5 Education: Giving children the tools to thrive
5.1 Early childhood development (ECD) programmes
5.2 Participation in primary and secondary education: growth and inequity
5.3 Literacy and opportunities for ‘second-chance’ education
5.4 Professional and technical education: equipping adolescents to enter the labour market
5.5 Learning achievement and education quality
5.6 Efficiency of the education system
5.7 The education reform and supply-side bottlenecks
5.8 Lowering demand-side barriers to education
5.9 Summary of priority actions

6 Protecting children from violence, abuse, exploitation, discrimination and social exclusion
6.1 Profile of vulnerability and risks
6.2 Building an integrated child protection system of preventive and responsive services
   6.2.1 Social care services
   6.2.2 Birth registration
   6.2.3 Justice for children
6.3 Summary of priority actions

7 Addressing child poverty through social protection
7.1 The role of cash transfers in building human capital and reducing poverty
7.2 Social transfers in Angola
7.3 Developing and scaling up cash transfer programme in Angola
7.4 Summary of priority actions

8 Conclusions and recommendations

Summary of recommendations

References

Annex A

Table A.1 Selected child and human wellbeing indicators: performance of upper middle-income Sub-Saharan African countries
Table A.2 Urban-rural disparities in child and human development indicators
Table A.3 Disparities in child and human development indicators, by wealth quintiles
List of Figures

Figure 1.1 Conceptual framework: child outcomes and their determinants 29
Figure 2.1 Real GDP growth rate in Angola and Sub-Saharan Africa (%), 2004-2012 34
Figure 2.2 Government finances: revenue and expenditure as % of GDP in Angola and Sub-Saharan Africa 35
Figure 2.3 Urban and rural population, 1970-2020 (UN Population Division) 37
Figure 3.1 Performance on key social development outcomes (literacy, nutrition and under-5 mortality): Where Angola ranks within the region, the world, and among upper middle-income Sub-Saharan Africa 46
Figure 3.2 Coverage of maternal and child health services and improved water and sanitation: Where Angola ranks within the region and among upper middle-income Sub-Saharan Africa 48
Figure 3.3 Access to education: Where Angola ranks on net attendance rates in primary and secondary school within the region and among upper middle-income countries in Sub-Saharan Africa 49
Figure 3.4 Urban-rural disparities in Angola for selected child and human development indicators 50
Figure 3.5 Disparities in child and human development by household wealth in Angola: Under-5 mortality, use of health services, water and sanitation and education 52
Figure 3.6 Gender parity indices for education and literacy by rural and urban residence, 2011 53
Figure 4.1 Child mortality estimates in Angola, 1990-2013: Deaths per 1,000 live births 56
Figure 4.2 Percentage of children under 5 sleeping under ITNs by area of residence, wealth quintile and education level of household head, 2011 59
Figure 4.3 Percentage of children under 5 with fever receiving ACT the same or next day after onset of fever by area of residence, education of mother and wealth quintile, 2011 60
Figure 4.4 Coverage of maternal health services in Angola, 2008 and 2011 61
Figure 4.5 Problems encountered in consultations at health facilities, as cited by patients who had a consultation in the 30 days prior to the survey (% of patients), 2011 63
Figure 4.6 Population per health facility and per physician by province, Angola, 2012 64
Figure 4.7 Main reasons given by parents for not taking children under 5 to health facilities when they were ill (during the 30 days preceding the survey) 66
Figure 4.8 Knowledge and practices related to malaria prevention in urban and rural areas of Angola, 2011 67
Figure 4.9 Percentage of women aged 12-19 who have given birth at least once by age group and residence 67
Figure 4.10 Under-nutrition in children aged 6-59 months by urban-rural residence and geographic regions, 2007 69
Figure 4.11 Regional, geographic and rural-urban disparities in consumption of iodized salt 71
Figure 4.12 Household food intake: Proportion of households consuming one, two or three or more meals per day by residence and wealth quintile, 2011 71
Figure 4.13 Proportion of children under 6 months exclusively breastfed by region (%), Angola, 2007 72
Figure 4.14 Coverage of HIV testing, treatment and PMTCT services, Angola, 2010-2011 76
Figure 4.15 Knowledge and practices related to HIV/AIDS (%) 77
Figure 4.16 Trends in use of improved water sources and sanitation facilities by urban and rural areas, Angola, 1990-2012 80
Figure 4.17 Use of surface water sources for drinking and open defecation, by wealth quintiles, 2011 81
Figure 5.1 Reasons given by parents for children aged 3-5 not attending ECD programmes 90
Figure 5.2 Net attendance ratios for primary and secondary education, by quintiles and areas of residence, 2011 92
Figure 5.3 Percentage of double orphans and of all children aged 10-14 attending school, Angola, 2008-2009 92
Figure 5.4 Net attendance ratios for primary and secondary education, by gender and area of residence, 2011 93
Figure 5.5 Adult literacy rates (aged 15 and above) above by gender and area of residence, Angola, 2011 94
Figure 5.6 Average number of primary school pupils per teacher and per classroom, 2008-2012 98
Figure 5.7 Reasons given by parents for children not attending or having never attended school (%), 2008-2009 102
Figure 6.1 Proportion of children living with both, one or neither of their parents, 2008-2009 108
Figure 6.2 Birth registration among children under 5 by residence and wealth quintile (% registered at birth), 2008-2009 109
Figure 6.3 Proportion of the population with disabilities and of the general population aged six and above that never went to school, 2008-2009 (%) 109
Figure 6.4 Barriers to birth registration: Main reasons given by mothers of children under 5 who did not register their children at birth for not doing so, by residence and quintiles 116
Figure 7.1 The components of social protection 122
Figure 7.2 Percentage of households receiving assistance in cash or kind by source of assistance and household characteristics, 2008-2009 127
Figure 7.3 Demographic trends and projections, Angola, 2000-2050 (% share of population by age group) 129

List of Tables

Table 2.1 Macroeconomic and public finance indicators, Angola, 2004-2012 35
Table 2.2 Population by province, 37
Table 2.3 Monetary poverty in Angola by population characteristics, 2008-2009 38
Table 4.1 Use of maternal health services by residence, educational level of household head, and wealth quintiles, 2011 61
Table 5.1 Learning achievement: % of grade 2 pupils passing reading/writing and numeracy tests based on grade 1 curriculum, 2005 96
Table 5.2 Teacher training: Percentage of all teachers without training by level in six provinces of Angola, 2010 99
Table 7.1 Major cash transfer programmes in Sub-Saharan Africa, 2012 125
Table 7.2 Examples of the impacts of cash transfers and PWPs 126

List of Boxes

Box 1.1 The Post-2015 Development Agenda 31
Box 2.1 Vulnerability and deprivation in the peri-urban slums of Angola 39
Box 3.1 Household wealth and inequities in child and human development indicators 51
Box 4.1 Causes of under-5 mortality in Angola 57
Box 4.2 Micronutrient deficiencies in Angola 70
Box 6.1 Vulnerability and protection for children with disabilities 109
Box 7.1 Social transfers and ‘demand’ for basic social services 123
Box 7.2 Social transfers in Africa 124
# Abbreviations and acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACS</td>
<td>Agentes comunitários de saúde (community health workers)</td>
</tr>
<tr>
<td>ACT</td>
<td>Artemisinin-based combination therapy</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute respiratory infections</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral therapy</td>
</tr>
<tr>
<td>AU</td>
<td>African Union</td>
</tr>
<tr>
<td>b/d</td>
<td>Barrels per day</td>
</tr>
<tr>
<td>CACS</td>
<td>Conselhos de Auscultação e Concertação Social (Councils for Social Consultation)</td>
</tr>
<tr>
<td>CASI</td>
<td>Centros de Acção Social Integrada (Integrated Social Action Centres)</td>
</tr>
<tr>
<td>CCT</td>
<td>Conditional cash transfer</td>
</tr>
<tr>
<td>CEC</td>
<td>Centros Educativos Comunitários (Community Education Centres)</td>
</tr>
<tr>
<td>CECOMA</td>
<td>Central de Compras e Aprovisionamento de Medicamentos (Central Organization for Purchase and Supply of Medicines)</td>
</tr>
<tr>
<td>CIC</td>
<td>Centros Infantis Comunitários (Community Child Centres)</td>
</tr>
<tr>
<td>CLTS</td>
<td>Community led total sanitation</td>
</tr>
<tr>
<td>cm</td>
<td>Centimetre</td>
</tr>
<tr>
<td>CMAM</td>
<td>Community Management of Acute Malnutrition</td>
</tr>
<tr>
<td>CNAC</td>
<td>Conselho Nacional da Criança (National Children’s Council)</td>
</tr>
<tr>
<td>CNAPEd</td>
<td>Conselho Nacional da Pessoa com Deficiência (National Council on Persons with Disabilities)</td>
</tr>
<tr>
<td>CPEE</td>
<td>Comissões dos Pais e Encarregados de Educação (Parents and Guardians Commissions)</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>CSG</td>
<td>Child Support Grant (of South Africa)</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil society organization</td>
</tr>
<tr>
<td>DPARS</td>
<td>Direcção Provincial de Assistência e Reinserção Social (Provincial Directorates of Social Assistance and Reintegration)</td>
</tr>
<tr>
<td>DPE</td>
<td>Direcção Provincial de Educação (Provincial Directorates of Education)</td>
</tr>
<tr>
<td>DPT</td>
<td>Diphtheria, pertussis and tetanus</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
</tr>
<tr>
<td>ECD</td>
<td>Early childhood development</td>
</tr>
<tr>
<td>ENSAN</td>
<td>Estratégia Nacional de Segurança Alimentar e Nutricional (National Food Security and Nutrition Strategy)</td>
</tr>
<tr>
<td>EPAL</td>
<td>Empresa Pública de Abastecimento de Água de Luanda (Luanda Public Water Company)</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>FSDEA</strong></td>
<td>Fundo Soberano de Angola (Angolan Sovereign Wealth Fund)</td>
</tr>
<tr>
<td><strong>GAM</strong></td>
<td>Global Acute Malnutrition</td>
</tr>
<tr>
<td><strong>GAR</strong></td>
<td>Gross attendance ratio</td>
</tr>
<tr>
<td><strong>GDP</strong></td>
<td>Gross domestic product</td>
</tr>
<tr>
<td><strong>g/L</strong></td>
<td>Grams per litre</td>
</tr>
<tr>
<td><strong>GNI</strong></td>
<td>Gross national income</td>
</tr>
<tr>
<td><strong>GPI</strong></td>
<td>Gender Parity Index</td>
</tr>
<tr>
<td><strong>HH</strong></td>
<td>Household</td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td><strong>IBEP</strong></td>
<td>Inquérito Integrado sobre o Bern-Estar da População (Population Welfare Survey)</td>
</tr>
<tr>
<td><strong>ILO</strong></td>
<td>International Labour Organization</td>
</tr>
<tr>
<td><strong>IMCI</strong></td>
<td>Integrated Management of Childhood Illness</td>
</tr>
<tr>
<td><strong>IMF</strong></td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td><strong>IMR</strong></td>
<td>Infant mortality rate</td>
</tr>
<tr>
<td><strong>IMPAC</strong></td>
<td>Integrated Management of Pregnancy and Childbirth</td>
</tr>
<tr>
<td><strong>INAC</strong></td>
<td>Instituto Nacional da Criança (National Children’s Institute)</td>
</tr>
<tr>
<td><strong>INCAPSIDA</strong></td>
<td>Inquérito sobre os Conhecimentos, Atitudes e Práticas sobre a SIDA (Survey on Knowledge, Attitudes and Practices on AIDS)</td>
</tr>
<tr>
<td><strong>INE</strong></td>
<td>Instituto Nacional de Estatística (National Statistics Institute)</td>
</tr>
<tr>
<td><strong>INEFOP</strong></td>
<td>Instituto Nacional de Emprego e Formação Profissional (National Institute of Employment and Professional Training)</td>
</tr>
<tr>
<td><strong>INFQ</strong></td>
<td>Instituto Nacional de Formação de Quadros</td>
</tr>
<tr>
<td><strong>INIDE</strong></td>
<td>Instituto Nacional Investigação e Desenvolvimento da Educação (National Institute of Research and Educational Development)</td>
</tr>
<tr>
<td><strong>INLS</strong></td>
<td>Instituto Nacional de Luta contra a SIDA (National Institute for the Fight against AIDS)</td>
</tr>
<tr>
<td><strong>IPF</strong></td>
<td>In-patient facilities</td>
</tr>
<tr>
<td><strong>ITN</strong></td>
<td>Insecticide-treated net</td>
</tr>
<tr>
<td><strong>JMP</strong></td>
<td>Joint Monitoring Programme for Water Supply and Sanitation (of UNICEF and WHO)</td>
</tr>
<tr>
<td><strong>KAP</strong></td>
<td>Knowledge, attitudes and practices</td>
</tr>
<tr>
<td><strong>Kz</strong></td>
<td>Kwanza</td>
</tr>
<tr>
<td><strong>MAM</strong></td>
<td>Moderate acute malnutrition</td>
</tr>
<tr>
<td><strong>MAPTSS</strong></td>
<td>Ministério da Administração Publica, Trabalho e Segurança Social (Ministry of Public Administration, Labour and Social Security)</td>
</tr>
<tr>
<td><strong>MAT</strong></td>
<td>Ministério da Administração Territorial (Ministry of Territorial Administration)</td>
</tr>
<tr>
<td><strong>MDGs</strong></td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>MED</td>
<td>Ministério da Educação (Ministry of Education)</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
</tr>
<tr>
<td>MINAGRI</td>
<td>Ministério da Agricultura, Desenvolvimento Rural (Ministry of Agriculture and Rural Development)</td>
</tr>
<tr>
<td>MINAMB</td>
<td>Ministério do Ambiente (Ministry of the Environment)</td>
</tr>
<tr>
<td>MINEA</td>
<td>Ministério da Energia e Água (Ministry of Energy and Water)</td>
</tr>
<tr>
<td>MINSA</td>
<td>Ministério da Saúde (Ministry of Health)</td>
</tr>
<tr>
<td>MINARS</td>
<td>Ministério da Assistência e Reintegração Social (Ministry of Social Assistance and Reintegration)</td>
</tr>
<tr>
<td>MINFAMU</td>
<td>Ministério da Família e Promoção da Mulher (Ministry of the Family and Promotion of Women)</td>
</tr>
<tr>
<td>MINFIN</td>
<td>Ministério das Finanças (Ministry of Finance)</td>
</tr>
<tr>
<td>MINPLAN</td>
<td>Ministério do Planeamento (Ministry of Planning)</td>
</tr>
<tr>
<td>MIS</td>
<td>Malaria Indicator Survey</td>
</tr>
<tr>
<td>MOGECa</td>
<td>Modelo de Gestão Comunitária de Água (Community Water Management Model)</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal mortality ratio</td>
</tr>
<tr>
<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
</tr>
<tr>
<td>NAR</td>
<td>Net attendance ratio</td>
</tr>
<tr>
<td>NSAP</td>
<td>National Social Assistance Policy</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>NNS</td>
<td>National Nutrition Survey</td>
</tr>
<tr>
<td>OGE</td>
<td>Orçamento Geral do Estado (General State Budget)</td>
</tr>
<tr>
<td>OTP</td>
<td>Outpatient therapeutic programmes</td>
</tr>
<tr>
<td>OVCs</td>
<td>Orphans and vulnerable children</td>
</tr>
<tr>
<td>PAAE</td>
<td>Programa de Alfabetização e Aceleração Escolar (Literacy and School Acceleration Programme)</td>
</tr>
<tr>
<td>PAEP</td>
<td>Projecto de Apoio ao Ensino Primário (Primary Education Support Project)</td>
</tr>
<tr>
<td>PAN-EPT</td>
<td>Plano de Acção Nacional – Educação para Todos (National Action Plan – Education for All)</td>
</tr>
<tr>
<td>PAS</td>
<td>Programa de Apoio Social (Social Support Programme)</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary health care</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission (of HIV)</td>
</tr>
<tr>
<td>PND</td>
<td>Plano Nacional de Desenvolvimento (National Development Plan)</td>
</tr>
<tr>
<td>PNDS</td>
<td>Plano Nacional de Desenvolvimento Sanitário (National Health Development Plan) 2012-2021</td>
</tr>
<tr>
<td>PNSA</td>
<td>Política Nacional de Saneamento Ambiental (National Environmental Sanitation Policy)</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>ppm</td>
<td>Parts per million</td>
</tr>
<tr>
<td>PSNP</td>
<td>Productive Safety Nets Programme (of Ethiopia)</td>
</tr>
<tr>
<td>PWP</td>
<td>Public works programme</td>
</tr>
<tr>
<td>Q</td>
<td>Quintile (household wealth; Q1 = 1st quintile, Q2 = 2nd quintile, Q3 = 3rd quintile, Q4 = 4th quintile, Q5 = 5th quintile)</td>
</tr>
<tr>
<td>QFO</td>
<td>Quasi-fiscal operations</td>
</tr>
<tr>
<td>QUIBB</td>
<td>Inquérito de Indicadores Básicos de Bem-Estar (Core Welfare Indicators Survey)</td>
</tr>
<tr>
<td>RME</td>
<td>Repartições municipais de educação (Municipal education departments)</td>
</tr>
<tr>
<td>SACMEQ</td>
<td>Southern African Consortium for Monitoring Educational Quality</td>
</tr>
<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
</tr>
<tr>
<td>SAM</td>
<td>Severe acute malnutrition</td>
</tr>
<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
</tr>
<tr>
<td>SICA</td>
<td>Sistema de Indicadores para a Criança Angolana (Angolan Child Indicator System)</td>
</tr>
<tr>
<td>SIGE</td>
<td>Education management information system</td>
</tr>
<tr>
<td>SIGFE</td>
<td>Sistema Integrado de Gestão Financeira do Estado (Integrated State Financial Management System)</td>
</tr>
<tr>
<td>SNFP</td>
<td>Serviço Nacional de Formação Professional (National Service of Vocational Training)</td>
</tr>
<tr>
<td>SONANGOL</td>
<td>Sociedade Nacional de Combustíveis (National Fuels Company)</td>
</tr>
<tr>
<td>SSA</td>
<td>Sub-Saharan Africa</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
</tr>
<tr>
<td>TFR</td>
<td>Total fertility rate</td>
</tr>
<tr>
<td>TVE</td>
<td>Technical and Vocational Education</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UN IGME</td>
<td>United Nations Inter-agency Group for Child Mortality Estimation</td>
</tr>
<tr>
<td>USD</td>
<td>United States Dollar</td>
</tr>
<tr>
<td>UTNSA</td>
<td>Unidade Técnica Nacional de Saneamento Ambiental (National Technical Unit for Environmental Sanitation)</td>
</tr>
<tr>
<td>U5MR</td>
<td>Under 5 mortality rate</td>
</tr>
<tr>
<td>VAD</td>
<td>Vitamin A deficiency</td>
</tr>
<tr>
<td>VAT</td>
<td>Value added tax</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>ZIP</td>
<td>Zonas de influência pedagógica (pedagogical influence zones)</td>
</tr>
</tbody>
</table>
Foreword

As Angola is completing its transition from a period of reconstruction to a phase of stable development, the country has a unique opportunity to build on successes to date and consolidate its status as an upper-middle income country where all segments of society enjoy the benefits of the increased wealth.

Of the 24 million Angolans, the majority (13 million) are children. Ensuring that these children and their families, increasingly and equally benefit from Angola’s social and economic development is the best investment that the country can make for the sustainability of growth and success in its future; to do so requires special consideration and targeted investment for the most vulnerable and impoverished members of Angolan society. Focusing on children is also a legal obligation that Angola committed to fulfil when it was among the first countries to sign the Convention on the Rights of the Child (CRC) in 1990.

Making use of the most recent available data and analysis, this situation analysis provides a comprehensive reference on the situation of children in Angola focusing in particular on progress towards ensuring their rights to survival, development and protection are respected, protected and fulfilled.

The report shows broadly that the situation of children in Angola has improved significantly since the end of the civil war. The Government of Angola has made major strides to strengthen the national policy framework in key areas related to child rights, while national performance on the vast majority of social indicators has improved. Angola now faces the challenge to implement policy and legal frameworks and bring services and protections directly to children and their families while removing the inequalities that currently hinder more dynamic progress.

This report is intended to contribute to the country’s efforts to successfully tackle these challenges by providing a holistic and evidence-based analysis of achievements to date, the factors that have helped or hindered progress and the risks and opportunities in the Angolan context. Within the areas of child survival, education, and protection, the report identifies actionable recommendations that have proven potential to yield rapid and sustainable results for children’s rights and wellbeing in Angola.

Angola stands at a key juncture with the resources to invest in the harmonious development of its children and their families and build a secure future for generations to come. UNICEF will continue to work alongside the Government of Angola and provide support for economic and social development that is sustainable and based on increasingly shared prosperity.

Francisco Ferreira Songane
UNICEF Representative in Angola
CHILDREN AND WOMEN IN ANGOLA SITUATION ANALYSIS
Executive Summary

During the years following the end of the civil war in 2002, Angola has enjoyed a rapid and sustained expansion of its economy and an enormous increase in government resources. From 2004 to 2012, Angola had the fastest growing economy in Sub-Saharan Africa.

The Government of Angola has made significant efforts to rebuild health and education systems and infrastructure devastated by nearly four decades of civil war. However, it remains a long and challenging journey to fully realize the rights of Angolan children and ensure that the benefits of economic growth are enjoyed equitably and sustainably.

This situation analysis takes stock of progress made to date in assuring the rights and wellbeing of Angola’s 13.2 million children, and analyses the factors that have facilitated or hindered development. Increased government resources present a precious opportunity for Angola to make meaningful investments in the health, education and protection of children and to continue the positive trajectory of post-war reconstruction and development.

This report aims to serve as a comprehensive reference on the situation of children in Angola with detailed analysis of the extent to which their rights to survival, development and protection are respected, protected and fulfilled. In each sector, the analysis provides an update on the status of key indicators across different population groups, examines relevant policy and legal frameworks, and assesses access to and quality of existing programmes and services.

The analysis is anchored within the framework of the Convention on the Rights of the Child (CRC) which was ratified by Angola in 1990. It is intended to contribute to decision-making processes in and across sectors that play a role in the protection and realization of children’s rights.

The analysis presented in this report is based on a comprehensive review and synthesis of available data. The analysis of trends in key social indicators was constrained in some cases by a lack of reliable and comparable data sources over time. Administrative data systems are weak in Angola and national survey data are also subject to several limitations.

The conceptual framework for this analysis is grounded in the relationships between child wellbeing or ‘outcomes’ and the immediate and underlying determinants of wellbeing. The status of child rights and wellbeing is analysed on two different levels: first, ‘outcomes’ such as child mortality, health and nutrition status, cognitive development, learning achievement and literacy, child poverty and freedom from violence and abuse; and second, ‘outputs’ or access to and use of basic services that contribute to the outcomes. The analysis then looks at underlying structural conditions and the ways in which these interact with intermediate factors such as the supply and quality of basic social services, standard of living in households, individual knowledge and practices, and environmental degradation and climate change, to influence the pace and equity of outcomes for children.

The country context

In 2002, Angola concluded four decades of near continual conflict and was able to focus energy and resources on building stability and accelerating economic and social development. The post-conflict period of stabilisation and recovery has brought rapid and sustained economic growth driven by expansion of the oil industry, as well as revitalized government engagement in promoting social and economic development.

1 13.2 million is estimated by applying the percentage used by the UN Population Division to estimate the proportion of the total population that is under age 18 in Angola (54 per cent) to provisional general population estimates from the 2014 Census.
In the post-conflict era, monetary poverty is estimated to have decreased substantially and rapid population growth and urbanization, environmental degradation and governance have emerged as key factors affecting the situation of children. The importance of investment in human capital is not yet adequately reflected in government spending priorities. Social sector expenditure remains relatively low, accounting for approximately one third of total government expenditure in recent years.

Rapid urbanization has led to the growth of huge informal settlements in and around all the major cities, and in particular around Luanda. The share of the population living in urban areas has soared to 58 per cent and urban population growth has put intense pressure on social infrastructure and services as well as on urban labour markets.

As of 2008, when poverty was last measured in a national survey, an estimated 37 per cent of Angolans lived below the national poverty line. Approximately 40 per cent of all children under age 15 were living in poverty and these children accounted for just over half the total number of poor. The incidence of poverty in rural areas (58 per cent) was three times higher than in the urban areas (19 per cent). The scale and depth of rural poverty stand in sharp contrast to the country’s significant agricultural potential. Angola’s small farmers rely on cultivation techniques that have low levels of productivity and contribute to food insecurity and environmental degradation.

Harnessing Angola’s resources to improve the infrastructure and services necessary for economic diversification and human capital development requires institutional reforms to strengthen governance. As part of a process of deconcentration, select government functions and expenditures have been moved from national to sub-national administrative levels; however this approach has resulted in limitations on the authority of line ministries over sub-national administrative bodies which have low capacity, especially outside the provincial capitals.

Equity: To what extent is progress in social and economic development enjoyed by all?

In 2012, Angola was reclassified by the World Bank as an upper-middle income country. This classification is based on per capita GNI but does not reflect the status of social development in Angola. Angola’s performance on social development indicators is mixed when analysed against Sub-Saharan Africa (SSA) as a whole and lagging when compared to other African countries in the upper middle-income bracket. To some extent, this can be attributed to the fact that Angola’s economic development is relatively recent and social development inherently takes more time to show improvement. To match the long-term social and economic performance of wealthy countries in Africa and beyond, Angola must make increasing investments in human capital starting during childhood.

Equity in key outcomes and access to basic social services

Rural areas of Angola are worse off than urban areas on all social development indicators, and in some sectors such as water and sanitation, secondary education, literacy, maternal health and child survival, the disparity is profound. Children in rural areas are one and a half times more likely to die before the age of 5 than children.

---

2 Law no 25/122 on ‘Proteção e Desenvolvimento Integral da Criança’ (Protection and Development of the Child) was adopted in 2012
in urban areas (IBEP 2008-2009). Only a quarter of rural births take place in health facilities, compared with three quarters in urban areas (QUIBB). Rates of child labour among children aged 10-17 were almost four times higher in rural areas than in urban areas and the rural net attendance rate (NAR) in secondary school is one fifth the rate in urban areas. The estimated proportion of the population using improved water sources for drinking in rural areas is only about half the level in urban areas and the proportion using improved sanitation facilities is just over one fifth that in urban areas (JMP).

Large inequities in child and human development are also associated with household wealth, although certain indicators show that even the ‘richest’ households may experience high levels of deprivation. Girls and women, orphans and people with disabilities experience added layers of disadvantage. In order to reduce inequality, there is a need to ensure that programmes and policies in social sectors explicitly tackle disparities.

**Ensuring children’s survival and health**

Since the end of the war, Angola has made progress in improving children’s chances of survival; however child mortality in Angola remains high and within the Angolan population, large disparities exist in health outcomes and access to health services and to clean water and sanitation facilities.

Malaria, diarrhoea and acute respiratory infections (ARI) account for the overwhelming majority of child deaths. While the Government of Angola promotes integrated approaches to health service delivery, these have not been applied in practice. New vaccines are being introduced through the Expanded Programme on Immunization (EPI); however, vaccination rates remain low. There has been a steady expansion of services for the prevention and treatment of malaria, but coverage falls short in many areas. Child mortality from infectious diseases could be reduced substantially by scaling up simple preventive and curative interventions. Coverage of maternal health services is increasing but remains low. There are also serious gaps in the quality of available maternal health services and large inequities in the use of maternal health services between wealth groups and urban and rural populations.

**Supply-side bottlenecks in health**

The National health Development Plan (Plano Nacional de Desenvolvimento Sanitário or PNDS) prioritises primary health care but the Government faces great challenges to achieve this in practice. The National Health Service has a total 2,356 health facilities, of which more than one fifth are not functioning and more than half do not have a supply of electricity. Many first-level health facilities are unable to provide a full set of basic services, the referral system is weak, and there are large deficits in health infrastructure in both urban and rural areas.

The National Health Service has a severe shortage of qualified personnel. According to WHO, Angola has only 0.08 physicians per 1,000 population and these are heavily concentrated in the major cities, especially Luanda. A sound human resource strategy is required and major initiatives are underway to increase the number of qualified health personnel. A strong system of community-based health promotion, prevention and basic curative care would complement and relieve pressure on facility-based services.

The PNDS provides a powerful framework for strengthening the health system and effective implementation requires a much stronger information system. Implementation of the PNDS will also require a large increase in health sector funding, which has received a declining share of the budget in recent years. In 2014, the health sector received 5 per cent of budgeted government expenditure (excluding debt service), just one third of the target of 15 per cent set by African governments in the Declaration of Abuja in 2001.

Access to health care depends not only on the supply and quality of health services but also on demand. Although the National Health Service officially provides health care free of charge, the cumulative costs of seeking care – including both the direct and opportunity costs – remain a barrier for many families. There are major gaps in health-related knowledge, attitudes and practices (KAP) with significant consequences for nutrition, hygiene and HIV/AIDS.
**Child Malnutrition**

Under-nutrition among children in Angola contributes significantly to child mortality and can cause permanent impairment to the cognitive development of young children compromising their well-being and productivity as adults. Almost one third of children aged 6-59 months suffered from stunting at the time of the last National Nutrition Survey (NNS) in 2007. While the prevalence of undernutrition in Angola is estimated to have decreased in the last years, it remains high. Chronic under-nutrition on the scale seen in Angola can have population-level impacts on human capital and pose a significant threat to national socio-economic development.

In addition to under-nutrition, micronutrient deficiencies threaten the growth, development and survival of infants and young children in Angola.

At a policy level, commitments have been made to scale up a comprehensive set of nutrition interventions however, there is a need to fully implement the policy provisions. The Government’s official package of measures for improving the nutrition of infants and young children is broadly consistent with global best practice but due to the lack of reliable, consolidated administrative data on nutrition programmes, it is difficult to assess the extent to which it is currently being implemented.

The drought emergency in 2012 and 2013 drove a major expansion of services for treatment of acute malnutrition in affected areas, but only a minority of affected children were reached and efforts to prevent acute malnutrition remain inadequate. Strengthening of institutional capacity and human resources for nutrition emerge as an urgent priority in Angola.

**Children and HIV/AIDS**

Angola has so far been spared from the human and economic ravages that HIV/AIDS has brought to other Southern African countries, but bottlenecks in service delivery and weaknesses in the health system leave no room for complacency. Adult HIV prevalence in Angola is currently estimated at 2.3 per cent and has been stable during past few years (UNAIDS 2013). However, the coverage of prevention, treatment and care interventions is low, particularly in the area of paediatric AIDS and the prevention of mother to child transmission (PMTCT). Eight out of ten pregnant women living with HIV in Angola do not receive antiretroviral medicines to prevent mother to child transmission (PMTCT). Angola is the only one of the 22 Global Plan priority countries in which the number of new HIV infections among children has continued to increase.

Gaps in ART coverage reflect low rates of HIV testing. Knowledge and practices are not conducive to protection against HIV infection, especially among women and in rural areas. Rapid investments are needed in capacity building, expansion of testing services, and improvement of drug and testing kit procurement and distribution.

**Water, sanitation and hygiene**

Lack of access to safe water and sanitation and poor hygiene practices are leading causes of infectious disease, contribute to under-nutrition and are a key driver of child mortality. In Angola major advances in both water and sanitation have been achieved in urban areas while rural areas have seen little to no progress in recent years. Increasing overall access to safe water requires improvements in the rural water supply. Approval of the National Environmental Sanitation Policy is urgently required to guide implementation and expansion in the sector.

Poor hygiene and behavioural practices are also a reason for concern. Behaviours contributing to the spread of disease include open defecation, the non-treatment of water for drinking and low rates of hand-washing. National-level data mask large disparities: poor Angolan families have far more limited access to safe water and sanitation than wealthier households. The poorest 20 per cent of Angolans overwhelmingly depend on surface water sources for their drinking water (60 per cent) and practice open defecation (74 per cent).
Education: Giving children the tools to thrive

Education is a fundamental human right guaranteed by the Constitution of Angola, and crucial for the economic and social wellbeing of the population and the long-term development of the country. Over the last decade Angola has made great strides in increasing access to education; the number of pupils enrolled in all levels of schooling increased more than fourfold from 2.2 million in 2001 to 9.5 million in 2014. However, further progress is required to tackle inequalities in access as well as to improve the quality of education.

Participation in ECD programmes by children under 6 remains low and there are concerns about the quality of primary grade zero (iniciação) classes. The allocation to pre-school education in the 2014 state budget is insufficient to achieve the major expansion of pre-primary education envisaged in the Education for All National Action Plan (PAN-EPT).

Increases in pupil enrolment were achieved through government investment in school infrastructure and teacher recruitment and deployment. While absolute pupil numbers have increased, secondary net attendance rates (NAR) and completion rates remain below average for Sub-Saharan Africa and major inequities in education are seen between urban and rural areas and wealth groups. Children who are orphans are much less likely to be in school, particularly those who have lost both parents. Although enrolment in special education has increased, few children with disabilities and special needs have access to schools. Angola has nearly achieved gender parity in primary education, though not yet in rural areas or at the secondary level. Secondary net attendance rates are particularly low for both boys and girls in rural areas.

Angola has made substantial progress in fighting illiteracy. Projections for 2015 estimate the adult literacy rate at 71 per cent (UNESCO 2014). In 2007, the Government adopted a strategy to strengthen literacy training and provide opportunities for adolescents and youth who left school early to return to their education. Overall, enrolment in literacy and adult education programmes increased, however these programmes are still not completely covering the need.

**Learning achievement and education quality**

The quality of education – and by extension, learning outcomes – remains an area of concern. Huge increases in the number of pupils, wide age mix in classrooms and inadequate inputs have all put huge pressure on the education system, undermining students’ learning. Poor cognitive development of preschool age children as a result of under-nutrition and micronutrient deficiencies and the lack of a supportive home environment for studying may also weaken learning outcomes. Investments in assessment of school quality and learning achievement are critical to monitor the performance of the education system and enable corrective measures to be taken, particularly in early grades.

**The education reform and supply-side bottlenecks**

Following the adoption of the Education System Basic Law in 2001, the Government has sought to improve the performance of the education system through a far-reaching education reform implemented in stages since 2004. Implementation of the reform has been beset with difficulties and despite large investments in school construction, the availability of classrooms has not kept pace with the rapid increase in the number of students. A top priority is to invest more in teachers, whose training, motivation and contact time with pupils are the most important determinants of the quality of education and can be significantly improved.

---

1 The most recent survey data available in Angola, is from the QUIBB 2011 which found an adult literacy rate of 66 per cent.
Primary education is officially free, but households must pay various associated costs out-of-pocket to send their children to school. As children become adolescents, work and pregnancy account for an increasing number of dropouts as opportunity costs overshadow the direct costs of school, particularly among older children. School feeding programmes should be expanded as a strategy to incentivize and facilitate school attendance, while adjusting the school calendar to accommodate agricultural cycles could mitigate the opportunity costs of education for children in rural areas.

**Protecting children from violence, abuse, exploitation, discrimination and social exclusion**

Children and especially those who are orphans experience heightened vulnerability to rights violations. An estimated 9.5 per cent of children in Angola are orphans of one or both parents and orphans account for only a small proportion of the numerous children who are not living with their biological parents (IBEP 2008-2009). Children who are living completely outside a family environment, such as children in prison and children living on the street, are amongst the most vulnerable. Disability raises the risks of deprivation and social exclusion for affected children.

Angolan labour law provides some degree of protection to children, however limited law enforcement undermines its efficacy and children in poor households and rural areas are at particularly high risk involvement in some form of labour. Domestic violence and abuse pose significant threats to women and children and incidents are widely underreported. Children, and especially girls, face risks associated with underage marriage and early pregnancy; 7 per cent of girls aged 12-14 and 55 per cent of girls aged 15-19 have already delivered their first baby. Early marriage and above all early pregnancy limit girls’ opportunities in life, often leading them to stop their education and affecting prospects for future employment.

While firmly established, the policy framework for child protection lacks operational clarity and implementation is lagging. The child protection system is weak and under-resourced in terms of both personnel and financing. Weaknesses in information, planning and budgeting pose significant constraints to implementation of child protection policies.

**Social care services**

In Angola, social assistance has evolved from a focus on humanitarian and reintegration assistance in the immediate post-war period to have a broader emphasis on the rights of vulnerable families and individuals. Government-run social care services for children are presently small-scale, underfunded, and poorly linked to other sectors.

The draft National Social Assistance Policy (NSAP) proposes the establishment of integrated social action centres (Centros de Acção Social Integrada or CASI) to fill the gap in frontline services beginning at municipal level. CASI would be staffed by social workers, requiring substantial investment in their training, an adjustment in municipal organigrams and the deployment of social workers to municípios across the country.

Improving access to the civil registration system is crucial for achieving the goal of universal birth registration, set in the Government’s National Development Plan. The majority of Angolan children (69 per cent) were not registered at birth and with no proof of their legal identity, they risk being unable to access their citizenship rights including essential social services. Poor rates of registration are due to weakness of registration services and other constraints on demand for registration.

**Juvenile justice**

Access to justice is an inalienable right of all children. Children entering in contact with the justice system should encounter specialised, age appropriate, speedy, and diligent processes that are adapted to the
needs and rights of the child and respect the best interest principle. In Angola, national legislation related to justice for children is well developed but there is a need for faster progress in the implementation of the Law on Juvenile Justice. Only one of the eighteen provinces – Luanda – has a specific court for children.

**Addressing child poverty through social protection**

A strong social protection system is fundamental to reduce the vulnerability of the poor to social risks, build their resilience to livelihood shocks and improve human capital and productivity. Though the current social protection system in Angola is weak, the draft NSAP lays solid foundations for strengthening and scaling up the coverage of social protection.

Social protection aims to strengthen the capacity of families to manage risks and shocks and to reduce their long-term vulnerability. Social cash transfers in particular have become an instrument of choice to build resilience, promote redistribution, facilitate access to social services and reduce long-term poverty. While informal solidarity mechanisms provide a kind of safety net at the community level, the formal social assistance system in Angola is still rudimentary; 12 per cent of households receive some form of assistance, the bulk of which comes as gifts from family and friends.

The main social transfer programme in Angola is the Programa de Apoio Social (PAS), which provided in-kind assistance to about 600,000 people in 2011, equivalent to about 3 per cent of the total population or 8 per cent of the population living in monetary poverty. Most assistance in Angola is short-term and sporadic, being provided mainly to respond to temporary shocks (Santos 2012 and OPM 2013a).

In line with the draft NSAP which includes cash transfers as a measure to reduce poverty and vulnerability, a new cash transfer programme is being piloted and other programmes are planned to enter the design stage in the near future. The draft NSAP combines the strengthening of social care services and the establishment of a system of social transfers with institutional reforms, giving special attention to grants for young children. Child grants will become progressively more affordable in Angola due to demographic changes and high rates of long-term economic growth.

**Conclusions and recommendations**

Angola must seize the opportunities presented by economic growth and stability to direct its focus and investment towards equity in social development. In order to do so, each policy and funding decision must deliberately target the most vulnerable and destitute segments of the population, to protect their rights, promote their wellbeing, and ensure the sustainability of development gains. Prioritising the most vulnerable members of the population will inherently have the greatest impact as investments where deprivation is most severe can yield meaningful results at a large scale.

**Child Survival and Development**

To accelerate reductions in child mortality, redoubled efforts will be needed across all the dimensions of health and wellbeing including the supply and quality of health services, household food security and child nutrition, access to water and sanitation, and families’ health-related behaviours. Priority recommendations include:

1. Scale up an integrated package of high-impact promotional, preventive and curative health services prioritising routine immunization, greater coverage of malaria interventions, and increased engagement with communities to improve health-related behaviours.

2. The comprehensive package of nutrition interventions identified in national policy documents needs to be translated into operational reality, prioritising behaviour-change interventions and strengthening human resources at all levels to deliver nutrition programmes.
3. Scale up the prevention and treatment of HIV and AIDS in children and adolescents as part of a broader drive to contain the disease and its impact.

4. Set up and rapidly expand community-based management of childhood diseases. This should start by ensuring that health policy in Angola adequately addresses the promotion, prevention and treatment of common childhood diseases at community level through community health resources.

5. Political commitment to primary health care needs to be realized in practice through increased investment in health infrastructure and human resources, particularly in rural areas, measures to end drug stock-outs, establishment of an effective referral system, increased community outreach and increased public expenditure on health.

6. Expand coverage of improved water sources and sanitation facilities, in particular in rural areas and peri-urban slum settlements through drilling and maintenance of village boreholes, use of community water management model in villages and peri-urban communities, expansion of community-led total sanitation (CLTS), and finalisation and implementation of the National Environmental Sanitation Policy.

7. Enhance communication activities to improve knowledge and promote behaviours conducive to better health.

**Education**

Progress made in increasing absolute pupil numbers must be consolidated with investments in the quality and equity of education to improve learning outcomes. Priority recommendations include:

8. Increase funding to early childhood education (ECD).

9. Improve quality of education through: strengthening pre-service and in-service training for teachers and increased funding for teacher retention and training.

10. Accelerate investment in school construction and maintenance at all levels of general education and in particular in secondary education. Ensure schools provide a safe and healthy learning environment for all children including girls and young women.

11. Increase demand for education through adoption of detailed regulations to enforce adherence to the principle of free primary education, identification of a viable school feeding model to be implemented nationally, and community awareness activities to promote the value of education, the importance that children start school at the correct age, and promoting completion of school.

12. Improve equity in education through enforcement of a policy framework to promote equal access to education for children with special needs and pilot measures to promote girls’ education at secondary school level, particularly in rural areas.

13. Strengthen planning, financing, management and monitoring of the education system with improvements to the education management information system and greater allocation of public expenditure to education; expenditure per pupil should aim to match that of other middle-income SADC countries.

14. Increase the allocation of public expenditure to education and aim to match the level of per-pupil expenditure in other middle-income SADC countries.

15. Assess school feeding programmes and roll out a viable national model as a solution to attract and retain children in schools particularly in deprived areas.
Child Protection

An integrated child protection system should provide preventive and responsive services at local level and ensure all children are registered and able to realize their rights to protection and justice and access related services. Priority recommendations include:

16. Establish front-line units for the provision of preventive and responsive protection services with legislation and regulations defining the purpose, functions and procedures of these structures.

17. Empower informal child protection networks at community level as pillars of an integrated response with training, financial resources and appropriate guidelines to regulate interaction with social services through referral systems.

18. Strengthen civil registration and vital statistics systems and adopt multi-sector strategies to facilitate access to birth registration and identification procedures.

19. Design and implement an appropriate model for justice for children in all provinces that clearly designates institutional responsibilities, procedures and provides for the training of personnel and budget allocations for provincial courts to offer specialized protection for children.

Social Protection

The adoption of the NSAP is the first step required to strengthen non-contributory social protection. Focus should then shift to adequate preparation for implementation of the measures included in the NSAP. Priority recommendations include:

20. Expand social protection on the basis of the NSAP as, once approved, it will provide a clear vision for the sector and help coordinate Government efforts.

21. Create a specialised national institution responsible for managing implementation of social transfers.

22. Carefully design programmes and implementation based on sound analysis and lessons learned from other countries; programme design must include clear criteria for targeting and registration of beneficiaries and a well-functioning M&E system.

23. Invest in building the administrative capacity and systems needed to implement the social protection programme, including the design and set-up of a computerized management information system and mechanisms for transferring payments to beneficiaries.

Chapter 1. Introduction

During the years following the end of the civil war in 2002, Angola has enjoyed a rapid and sustained expansion of its economy and an enormous increase in government resources. From 2004 to 2012, Angola had the fastest growing economy in Sub-Saharan Africa, with the gross domestic product (GDP) increasing on average 11.5 per cent annually.

The economic boom followed nearly four decades of civil war that devastated public infrastructure and services and resulted in massive population migration to urban centres. While Angola has made significant efforts to rebuild health and education systems and strengthen governance, it remains a long and challenging journey to fully realize the rights of Angolan children and ensure that the benefits of economic growth are enjoyed equitably and sustainably.

This situation analysis takes stock of progress made to date in assuring the rights and wellbeing of Angola’s 13.2 million children, and analyses the factors that facilitate or hinder development. Increased government resources present a precious opportunity for Angola to make meaningful investments in the health, education and protection of children and to continue the positive trajectory of post-war reconstruction and development.

1.1 Objectives of the situation analysis

This report aims to serve as a comprehensive reference on the situation of children in Angola with a detailed analysis of the extent to which their rights to survival, development and protection are respected, protected and fulfilled. In each sector, the analysis provides an update on the status of key indicators across different population groups, examines relevant policy and legal frameworks, and assesses access and quality of existing programmes and services.

This analysis is intended to contribute to decision-making processes in and across sectors that play a role in the protection and realization of children’s rights. It is hoped that key stakeholders and decision makers use the analysis and recommendations in this report as a reference for programming and policy-making.

The analysis is anchored within the framework of the Convention on the Rights of the Child (CRC) which was ratified by Angola in 1990. The structure of the report follows the rights framework established in the CRC. Following this introductory chapter and a summary of Angola’s social and economic context (Chapter 2), Chapter 3 provides an overview of the country’s performance with respect to the rights and wellbeing of children. This overview presents current national level data alongside data disaggregated by area of residence and household wealth in order to assess equity in the realization of child rights within Angola. Chapter 3 contrasts Angola’s performance with that of Sub-Saharan Africa as a whole and with a ‘peer group’ of other upper middle-income countries in Sub-Saharan Africa for a deeper understanding of development in relation to government resources. Subsequent chapters assess Angola’s performance in the realization of specific rights for children including survival (Chapter 4), development (Chapter 5) and protection (Chapters 6 and 7), analysing the pace, degree and trends of progress as well as related determinants and obstacles. Detailed conclusions and recommendations follow sector-level analysis in each chapter and are summarised in the final chapter of this report (Chapter 8).

13.2 million is estimated by applying the percentage used by the UN Population Division to estimate the proportion of the total population that is under age 18 in Angola (54 per cent) to provisional general population estimates from the 2014 Census.
1.2 Methods and limitations

This report was developed by the UNICEF Angola country office with the support of a consultancy team from Oxford Policy Management (OPM) and in consultation with the UNICEF Regional Office for Eastern and Southern Africa based in Nairobi.

The analysis presented in this report is based on a comprehensive review and synthesis of data from a variety of sources including national household surveys, sector-specific routine information systems, government and NGO programme data, and small scale studies and research. Data from national surveys and routine information systems were assessed for quality and reliability and used whenever possible. Estimates based on census data have been updated using the provisional population estimates from the 2014 general population census. Where relevant data was missing or could not be validated – which was particularly the case for historical data required for trend analysis – the report relies on estimates from models produced by global institutions. A number of national and international evaluations and studies were also used in this analysis. A full list of references is provided at the end of the report.

The analysis of trends in key social development indicators was constrained in some cases by a lack of reliable and comparable data sources over time. As in many developing countries, administrative data systems are weak in Angola. These systems mainly track the use of public services in specific sectors. Data reported from service points is often incomplete and these systems lack capacity to validate missing or inconsistent data. Nationally representative surveys were therefore preferred as sources for data on coverage and utilization of services as well as analysis of individual and population-level outcomes. However, these surveys are also subject to significant limitations. Firstly, the most recent comprehensive national survey providing data on key social and poverty indicators – the Inquérito Integrado sobre o Bem-Estar da População (IBEP) 2008-2009 – was already seven years old at the time of writing. Second, surveys conducted before the end of the war in 2002 are not considered to be nationally representative due to the fact that areas heavily affected by conflict were inaccessible to survey teams and therefore were not represented in survey findings.

1.3 Conceptual framework

The conceptual framework for this analysis is grounded in the relationships between child wellbeing or ‘outcomes’ and the immediate and underlying determinants of wellbeing. This framework is represented by a ‘problem tree’ (see Figure 1.1) which simplifies complex relationships into four levels: outcomes (represented by the leaves), outputs (branches), intermediate determinants (the trunk) and fundamental determinants (roots).
Figure 1.1 Conceptual framework: child outcomes and their determinants

The leaves and branches of the ‘problem tree’ represent the status of child rights and wellbeing on two different levels: first, the leaves representing ‘outcomes’ such as child mortality, health and nutrition status, cognitive development and learning achievement, violence and abuse; and second, the upper branches representing ‘outputs’ or access to and use of basic services that contribute to the outcomes. These services include preventive and curative health services, education, safe drinking water sources and sanitation, birth registration, social care services, social protection, and a justice system. Although both levels of rights feature in the CRC and other human rights instruments, this report takes care to distinguish them, addressing access to services as an intermediary level contributing to outcomes for children. It may be noted that some of the indicators measuring access and outcomes are the same indicators used for tracking progress towards the Millennium Development Goals (MDGs).
Chapter 1. Introduction

The roots of the tree represent underlying structural factors that determine the pace and equity of progress. These fundamental determinants exist at a deeper societal level, affecting access to basic services and child outcomes through various intermediate channels. Fundamental determinants are grouped into four different types: economic (including growth, distribution and poverty); environmental (including climate change), cultural including gender; and determinants related to governance. These four types of determinants are not mutually exclusive; indeed, they are highly interdependent and considered holistically, are both cause and effect of a country’s overall level of economic and social development. For example, poverty reflects and conditions social and economic development, contributes to and is affected by environmental degradation, and interacts with socio-cultural norms and practices, often through education. Governance, interpreted here to mean the framework of laws, institutions, policies and public finances, both reflects the level of development while also determining the pace and nature of its progress.

The middle or trunk of the tree represents intermediate factors linking root determinants with access to services and ultimately outcomes for children. These intermediate levels have been greatly simplified in Figure 1.1, as the interactions are far too complex to represent in a diagram. In this part of the tree, supply and quality of basic social services interact with the standard of living in households and their financial access to social services, individual knowledge, attitudes and practices, and environmental degradation and climate change. The supply and quality of basic services refers to the infrastructure and human resources, supply chains and other factors affecting the availability and delivery of basic social services. Household standard of living concerns household consumption, ownership of assets and the direct and indirect costs of accessing services such as schools and health facilities. Knowledge, attitudes and practices often reflect underlying socio-cultural factors as well as education and access to information. Finally, climate change and environmental degradation contribute to increased incidence and severity of natural disasters and their impacts, for example on seasonal food insecurity in rural populations largely dependent on rain-fed agriculture and the raising of livestock.

This report presents an analysis of children’s rights to survival, development and protection at each level of the problem tree, assessing the current status of children’s wellbeing, their access to basic services, and tracing the interactions of intermediary and underlying determinants. Conclusions and recommendations take into account the unique context and opportunities presented by Angola’s recent economic growth and political commitment to development.
Box 1.1 The Post-2015 Development Agenda

The present report uses the Millennium Development Goals (MDGs) and related target indicators as a reference to measure the progress of development in Angola. As the era of the MDGs comes to a close in 2015, the post-2015 development agenda and associated indicators are currently being drafted and will serve as the new international framework for human development. At the time of writing, the new framework, goals and targets – to be known as the Sustainable Development Goals (SDGs) – are still being discussed. This analysis references key MDG indicators but is grounded in the conceptual framework outlined above to maintain relevance in anticipation of a finalized post-2015 agenda.

The United Nations system is undertaking an unprecedented effort to bring the voices of communities into the dialogue surrounding the Post-2015 Agenda. In 2013, public consultations were held in a number of countries, including Angola. The national consultation in Angola brought together representatives from civil society organisations (CSOs), the government, bilateral and multilateral organizations, children and youth. The aim of these consultations was to generate contributions to a global agenda that will reflect the aspirations of people from every part of the country, of all ages, and from all walks of life.

At the centre of these efforts is the Open Work Group (OWG) on Sustainable Development Goals. The OWG was established following the 2012 United Nations Conference on Sustainable Development, known as Rio+20. Consisting of 70 Member States sharing 30 seats, the OWG has been working to develop SDGs for consideration by the UN General Assembly.

The OWG report finalised in July 2014 captures issues of importance for children, identifying strengths of the MDGs and highlighting areas the MDGs failed to adequately recognize or address, including inequality, violence against children and child poverty. Perhaps one of the most fundamental lessons learned from the MDGs was the need to look beyond national and global data at equity to truly understand progress.
Chapter 2.
The country context

Thirteen years ago in 2002, Angola concluded four decades of near continual conflict and redirected its attention forward on stability and economic and social development. From 1961 to 1975, Angola was embroiled in the Colonial War for independence from Portugal. In 1975, independence and the departure of the Portuguese opened a new era of violence and instability, as armed political factions fought each other for power. At its height, Angola became a flashpoint for the Cold War and the civil conflict was intensified with the involvement of foreign powers as the country was also entwined in regional struggles. Half a million Portuguese settlers fled Angola at independence and during the civil war that followed, millions of Angolans were also displaced, fleeing to neighbouring countries or for the most part, settling in the cities to seek protection from fighting in the bush. The economic and human costs of the conflict – amplified by these mass migrations – were immense.

Since 2002, the post-conflict period of stabilization and recovery has brought rapid and sustained economic growth driven by expansion of the oil industry, as well as revitalized government engagement in promoting social and economic development. As Section 2.1 will describe, rapid growth of oil production and high global oil prices have fuelled an economic boom and generated larger than ever revenues for the Government of Angola. From a public finance perspective, few African countries are as well placed as Angola to make the investments needed to ensure that children survive and develop as healthy and well-educated citizens, contributing as adults to further economic growth and development.

Monetary poverty\(^4\) is estimated to have decreased substantially following the end of the conflict\(^7\). Despite real improvement, the last national household survey on living conditions conducted in 2008-2009, found that more than one third of the population still lived below the poverty line. As Section 2.2 will discuss, Angola’s greatest challenge now is to maximize the opportunities presented by oil revenues, using new wealth strategically and sustainably to finance investments needed to diversify the economy, build human capital and accelerate improvements in the well-being of its population.

In the post-conflict era, rapid population growth and urbanization, environmental degradation and governance are key factors affecting the situation of children. Due to displacement during the war, limited economic opportunities and poor availability and quality of public services in rural areas, Angola has become one of the most urbanized countries in Africa. Section 2.3 discusses how massive urbanization has led to the growth of unplanned peri-urban settlements that present huge challenges for employment and the provision of public services, including housing, water, sanitation, schools and health facilities. Section 2.4 describes the vulnerability of rural populations dependent on rain-fed agriculture and draws attention to ongoing environmental degradation and livelihood risks associated with climate change. Governance is discussed in Section 2.5 with particular focus on planning and public financial management systems and the effects of decentralization on the quality and accessibility of essential public services for the wellbeing of children. Section 2.6 concludes the chapter with an analysis of the legal and policy framework for child rights in Angola.

---

\(^4\) Monetary poverty is measured by defining a basket of food and non-food items that is judged sufficient to meet basic necessities; the value of this basket represents the poverty line.

\(^7\) In Angola, the comparison of monetary poverty rates over time presents challenges due to “significant differences in methodology (used) to measure poverty, the type of survey employed in geographic coverage, the sample and the duration of the fieldwork” (IBEP, Vol. 1, INE, 2011). Despite such limitations, a number of studies (Assunção, 2006; UCAN, 2010, PNUD 2006, PNUS 2008) suggest that poverty increased during the 1990s, peaking with an estimated 68 percent of the population living below the poverty line in 2001. Poverty began to decline again in the early 2000s, coinciding with the end of the armed conflict.
2.1 Post-conflict economic boom: Angola as an upper middle-income oil producer

During the last decade, Angola recorded one of the highest rates of GDP growth in the world. Real GDP growth peaked at over 20 per cent a year in 2005-2007 averaging 11.5 per cent per year during the nine-year period from 2004 to 2012. GDP growth in Angola was more than twice as high as for Sub-Saharan Africa as a whole (5.8 per cent) and substantially more than the average growth rate in other oil-exporting countries in the region (7.6 per cent) during the same period (IMF 2013 and 2014). Growth slowed abruptly in the wake of the global economic crisis but has resumed, reaching 5.2 per cent in 2012 (IMF 2014). That year, with a per capita gross national income (GNI) of US$4,580, Angola was classified by the World Bank as an upper middle-income country, joining just five other Sub-Saharan African countries with this ranking: Botswana, Gabon, Mauritius, Namibia and South Africa. Angola now has the third largest economy in Sub-Saharan Africa, after South Africa and Nigeria.

Growth has been fuelled mainly by oil, with oil production quadrupling in the past quarter-century from 474,000 barrels a day (b/d) in 1990 to 748,000 b/d in 2000 and 1.73 million b/d in 2012. Angola is now the second largest producer of oil in Sub-Saharan Africa, currently producing about 70 per cent as much oil as Nigeria which has a population roughly 8 times the size of Angola’s population. The resources generated by the oil industry have the potential to have a massive impact on poverty and social development and improve the prospects and wellbeing of children in Angola.

Oil accounts for most government revenue enabling high levels of government expenditure. Oil-exporting countries generally have high ratios of government revenue to GDP resulting from heavy taxation of the oil industry. In Angola, the revenue/GDP ratio averaged 45 per cent over the period 2004-2012 (see Figure 2.2) (IMF 2013 & 2014). As a result, government expenditure has also been very high relative to GDP. Expenditure averaged approximately 39 per cent of GDP over the period 2004-2012, compared to about 27 per cent in Sub-Saharan Africa as a whole (see Figure 2.2). Meanwhile, GDP growth has led to a large expansion in the absolute level of public expenditure albeit with a sharp fiscal correction in 2010-2011 in the wake of the global economic crisis. By 2012, per capita government expenditure had risen to US$2,260 – 88 per cent higher than in 2004.11

Figure 2.1 Real GDP growth rate in Angola and Sub-Saharan Africa (%), 2004-2012

Growth has been fuelled mainly by oil, with oil production quadrupling in the past quarter-century from 474,000 barrels a day (b/d) in 1990 to 748,000 b/d in 2000 and 1.73 million b/d in 2012. Angola is now the second largest producer of oil in Sub-Saharan Africa, currently producing about 70 per cent as much oil as Nigeria which has a population roughly 8 times the size of Angola’s population. The resources generated by the oil industry have the potential to have a massive impact on poverty and social development and improve the prospects and wellbeing of children in Angola.

Oil accounts for most government revenue enabling high levels of government expenditure. Oil-exporting countries generally have high ratios of government revenue to GDP resulting from heavy taxation of the oil industry. In Angola, the revenue/GDP ratio averaged 45 per cent over the period 2004-2012 (see Figure 2.2) (IMF 2013 & 2014). As a result, government expenditure has also been very high relative to GDP. Expenditure averaged approximately 39 per cent of GDP over the period 2004-2012, compared to about 27 per cent in Sub-Saharan Africa as a whole (see Figure 2.2). Meanwhile, GDP growth has led to a large expansion in the absolute level of public expenditure albeit with a sharp fiscal correction in 2010-2011 in the wake of the global economic crisis. By 2012, per capita government expenditure had risen to US$2,260 – 88 per cent higher than in 2004.11

---

1 At the height of the global crisis in 2009, Angola experience negative per capita growth.

9 World Bank Country and Lending Group classifications are based on the Gross National Income (GNI) per capita. In 2012, upper middle-income countries were those with per capita GNI of US$4,036 to $12,475. This classification does not take other human development indicators into account and does not imply that all countries in a given bracket are experiencing similar levels of development.

10 In Sub-Saharan Africa, this ratio was 32 per cent for the oil exporting countries in 2004-2012, compared with 28 per cent for the region as a whole (IMF 2013).

11 Measured at 2004 constant prices and exchange rates.
Figure 2.2 Government finances: revenue and expenditure as % of GDP in Angola and Sub-Saharan Africa

Table 2.1 Macroeconomic and public finance indicators, Angola, 2004-2012

<table>
<thead>
<tr>
<th></th>
<th>2004-2012 (mean)</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real GDP growth (%)</td>
<td>11.5</td>
<td>22.6</td>
<td>13.8</td>
<td>2.4</td>
<td>3.4</td>
<td>3.7</td>
<td>10.8</td>
</tr>
<tr>
<td>GNI per capita (USD)</td>
<td>$2,893</td>
<td>$2,560</td>
<td>$3,270</td>
<td>$3,800</td>
<td>$3,870</td>
<td>$3,970</td>
<td>$4,580</td>
</tr>
<tr>
<td>Government revenue (% of GDP)</td>
<td>44.8</td>
<td>45.8</td>
<td>50.9</td>
<td>34.5</td>
<td>43.5</td>
<td>48.8</td>
<td>45.9</td>
</tr>
<tr>
<td>Government expenditure (% of GDP)</td>
<td>39.0</td>
<td>34.5</td>
<td>42.0</td>
<td>41.9</td>
<td>40.0</td>
<td>40.2</td>
<td>40.8</td>
</tr>
<tr>
<td>Public debt (% of GDP)</td>
<td>35.9</td>
<td>21.4</td>
<td>31.6</td>
<td>36.4</td>
<td>37.6</td>
<td>31.5</td>
<td>29.3</td>
</tr>
<tr>
<td>Oil production (millions of barrels/day)</td>
<td>1,599</td>
<td>1,747</td>
<td>1,979</td>
<td>1,809</td>
<td>1,755</td>
<td>1,660</td>
<td>1,731</td>
</tr>
</tbody>
</table>


Heavy dependence on oil is also a source of vulnerability, as oil is a finite resource and swings in global oil prices expose Angola to periodic economic shocks. Long-term production trends are hard to predict and it is unknown if and for how long new discoveries might replace production from existing oil fields which is expected to decline from 2017 (IMF 2014). Angola is also vulnerable to price shocks, as shown by the crisis triggered by the fall in oil price in 2008-2009 when, at the pick of the international financial crisis, the sudden fall of oil price resulted in a 42 per cent decrease of the value of export and in a 16 per cent drop of fiscal revenue in percentage to the GDP (see table 2.1). More recently, the decrease in oil price that started in mid-2014 (prices fell from USD 115 to USD 59 p/b in the second semester of 2014) is estimated to result in a fall of the value of the Angolan export of around US$ 27 billion in 2015; while fiscal revenue is forecasted to drop by USD 17 billion. While Angola is today much better equipped to deal with the consequences of the drop in oil price than it was in 2008, the actual impact of the price shock on the country will ultimately depend on the one hand on its duration and on the other hand on the effectiveness of the fiscal and monetary measures adopted by the Government. Regardless, most forecast predict that the drop in oil price is a temporary occurrence and that prices are likely to move upward in the course of 2015 and reach USD 75-80 p/b (IMF 2014).
Angola is making substantial efforts to diversify its economy. The oil sector not only provides a large part of government revenue, but directly accounts for almost one half of GDP\(^\text{12}\). Indirectly, the oil sector also plays a huge role in the economy, as much of the non-oil GDP from sectors such as energy, water, construction, roads and other infrastructure, depends heavily on public investment financed by oil revenue. However, excluding the indirect channels of taxation and government expenditure, the oil industry has weak linkages to the rest of the economy and provides relatively little employment. The Angolan Government is well aware of the need to diversify the economy beyond the oil sector to promote more inclusive and sustainable growth, create large-scale employment and reduce poverty, as well as reduce the country’s vulnerability to oil market shocks. Diversification is one of the key goals of the long-term development strategy articulated in Angola 2025 (MINPLAN 2004), and requires substantial investments in both physical and human capital, as well as an improved business climate. Investments in human capital begin in childhood with the realization of children’s rights and wellbeing and reap great returns in the long-term as young generations grow into the healthy, well-educated workforce needed for a dynamic, competitive and more resilient economy.

The importance of investments in human capital is not yet adequately reflected in government spending priorities. Social sector expenditure remains relatively low, accounting for approximately one third of total government expenditure in the recent years. The social sectors were allocated 30 per cent of the 2014 budget (MINFIN 2014)\(^\text{13}\). Education expenditure in Angola accounted for only 7 per cent of total government expenditure in the 2014 budget – among the lowest rates in Africa – and has been declining since 2011 (see Section 5.8). The share of health expenditure has also declined, falling to 5 per cent of total government expenditure in the 2014 budget, far below the target of 15 per cent set by the African Union in the Declaration of Abuja in 2001 (see Section 4.2).

### 2.2 Population and urbanization

Angola’s population is very young; more than half of all Angolans are under the age of 18. The UN Population Division estimates that the total population of Angola increased by an average annual rate of 3.3 per cent from 2005-2010, compared to an average population growth rate of 2.7 per cent for Sub-Saharan Africa as a whole. The preliminary results of the general Population Census conducted in May 2014\(^\text{14}\) indicate that the Angolan population has reached 24.4 million; much larger than the UN Population Division and the Angolan National Statistics Institute (Instituto Nacional de Estatística or INE) had projected. Rapid population growth in Angola is due mainly to a high fertility rate, which is above average for Sub-Saharan Africa.\(^\text{15}\) As a result, the proportion of the population who are children and adolescents under the age of 18 is also particularly large: 54 per cent compared with 50 per cent for Sub-Saharan Africa as a whole and 31 per cent worldwide. Nearly one in five Angolans (19 per cent) is under 5 years old (UNICEF, 2014).

Angola has become one of the most urbanized countries in Africa over a very short period of time. In just 40 years, from 1970 to 2010, the share of the population living in urban areas soared from 15 per cent to 58 per cent, according to the UN Population Division (see Figure 2.3). The preliminary results of the 2014 Population Census found that 62 per cent of Angolans live in urban areas and that more than a quarter of the entire population lives in the national capital, Luanda (27 per cent in 2014, see Table 2.3). Rapid urbanization was accelerated by massive population displacements during the war and has created major challenges for urban planning, housing, water supply and the provision of social infrastructure in the cities (see Box 2.1), while leaving the rural areas sparsely populated.

---

\(^\text{12}\) 47 per cent in 2012 according to the Banco Nacional de Angola.

\(^\text{13}\) In the preliminary 2015 state budget, social sector allocation has increased slightly reaching almost 34 per cent.

\(^\text{14}\) The preliminary results of the Census were released in October 2014.

\(^\text{15}\) Estimates of the total fertility rate (TFR) vary from 5.4 per cent (in IBEP 2008-2009) to 6.0 per cent (UN estimate for 2012) and 6.3 per cent (from data collected in a national malaria survey in 2011). These estimates compare to an average of 5.2 per cent for Sub-Saharan Africa (UNICEF, 2014). Recently population growth may also be driven by economic growth and/or reflect that previous figures may have slightly underestimated total population.
### Table 2.2 Population by province, 2014 (INE 2014)

<table>
<thead>
<tr>
<th>Province</th>
<th>Number</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cabinda</td>
<td>688,285</td>
<td>2.8</td>
</tr>
<tr>
<td>Zaire</td>
<td>567,225</td>
<td>2.3</td>
</tr>
<tr>
<td>Uíge</td>
<td>1,426,354</td>
<td>5.8</td>
</tr>
<tr>
<td>Luanda</td>
<td>6,542,944</td>
<td>26.8</td>
</tr>
<tr>
<td>Kwanza Norte</td>
<td>427,971</td>
<td>1.8</td>
</tr>
<tr>
<td>Kwanza Sul</td>
<td>1,793,787</td>
<td>7.4</td>
</tr>
<tr>
<td>Malange</td>
<td>968,135</td>
<td>4.0</td>
</tr>
<tr>
<td>Lunda Norte</td>
<td>799,950</td>
<td>3.3</td>
</tr>
<tr>
<td>Benguela</td>
<td>2,036,662</td>
<td>8.4</td>
</tr>
<tr>
<td>Huambo</td>
<td>1,896,147</td>
<td>7.8</td>
</tr>
<tr>
<td>Bié</td>
<td>1,338,923</td>
<td>5.5</td>
</tr>
<tr>
<td>Mexico</td>
<td>727,594</td>
<td>3.0</td>
</tr>
<tr>
<td>Kuando Kubango</td>
<td>510,369</td>
<td>2.1</td>
</tr>
<tr>
<td>Namibe</td>
<td>471,613</td>
<td>1.9</td>
</tr>
<tr>
<td>Huila</td>
<td>2,354,398</td>
<td>9.7</td>
</tr>
<tr>
<td>Cunene</td>
<td>965,288</td>
<td>4.0</td>
</tr>
<tr>
<td>Lunda Sul</td>
<td>516,077</td>
<td>2.1</td>
</tr>
<tr>
<td>Bengo</td>
<td>351,579</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>24,383,301</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Sources: UN Population Division 2013 (for urban and rural population) and INE 2014 (for population by provinces).

### 2.3 Monetary poverty

As of 2008, when poverty was last measured in a national survey, an estimated 37 per cent of Angolans live below the national poverty line\(^{16}\).\(^{17}\). Within poor households, monthly expenditures fell on average 13 percentage points below the poverty line; in other words the ‘poverty gap’ was 13 per cent\(^{18}\) (IBEP 2008-2009).

Approximately 40 per cent of all children under age 15 were living in poverty and these children accounted for just over half the total number of poor (see Table 2.2). A higher incidence of poverty (or ‘poverty headcount’) among children as compared to the population as a whole is typical and reflects the fact that the poor tend to have larger households than the non-poor. The elderly (aged > 65 years) were also found

---

\(^{16}\) The poverty line is the standard method used to measure the proportion of people living in ‘monetary poverty’. The poverty line corresponds to the value of a basket of food and non-food items that is judged sufficient to meet basic necessities. In Angola the national poverty line was defined as Kz 4,973 (approximately USD $50) per month per person at the time of the last national survey that collected data on poverty. This means that individuals with a level of monthly consumption below this amount were classified as poor.

\(^{17}\) The Population Welfare Survey (Inquérito Integrado sobre o Bem-Estar da População or IBEP) conducted in 2008-2009 provides the most recent data on poverty in Angola.

\(^{18}\) The Poverty Gap (Depth of poverty) provides information regarding how far poor households are from the poverty line. This measure captures the average difference between poor households’ expenditure and the poverty line.
to have a higher than average poverty incidence (40 per cent) but accounted for only 2.7 per cent of the total number of poor as this age group makes up a relatively small proportion of the population.

Poverty is much higher in rural areas than in the cities. Poverty incidence in rural areas (58 per cent) was three times higher than in the urban areas (19 per cent), and the rural poverty gap was 22 per cent compared with 13 per cent nationally and 5.3 per cent in the urban areas. Despite greater incidence and depth of poverty in rural areas, urban poor still account for a significant portion (28 per cent) of the total population living in poverty due to the greater size of urban populations. Although the IBEP did not disaggregate between households in the central parts of cities and those in less developed peri-urban areas, it would likely have found large disparities in poverty levels between these two very different urban settings (see Box 2.1).

Table 2.3 Monetary poverty in Angola by population characteristics, 2008-2009

<table>
<thead>
<tr>
<th>Poverty indices (%)</th>
<th>Headcount (incidence)</th>
<th>Depth (poverty gap)</th>
<th>Severity (^9) (square gap)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>36.6</td>
<td>12.7</td>
<td>6.0</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>18.7</td>
<td>5.3</td>
<td>2.2</td>
</tr>
<tr>
<td>Rural</td>
<td>58.3</td>
<td>21.6</td>
<td>10.7</td>
</tr>
<tr>
<td>Age groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children (0-14 years)</td>
<td>40.2</td>
<td>14.1</td>
<td>6.7</td>
</tr>
<tr>
<td>Youth (15-24 years)</td>
<td>30.5</td>
<td>10.2</td>
<td>4.7</td>
</tr>
<tr>
<td>Elderly (\ (&gt; 65 years)</td>
<td>39.9</td>
<td>12.4</td>
<td>6.0</td>
</tr>
<tr>
<td>Characteristics of household head</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed in agriculture</td>
<td>66.2</td>
<td>25.6</td>
<td>12.8</td>
</tr>
<tr>
<td>Self-employed</td>
<td>53.1</td>
<td>19.8</td>
<td>9.7</td>
</tr>
<tr>
<td>Male</td>
<td>37.4</td>
<td>13.0</td>
<td>6.2</td>
</tr>
<tr>
<td>Female</td>
<td>33.2</td>
<td>11.1</td>
<td>5.2</td>
</tr>
<tr>
<td>Aged \ (&gt; 65 years)</td>
<td>46.5</td>
<td>17.6</td>
<td>9.2</td>
</tr>
<tr>
<td>With no education</td>
<td>61.7</td>
<td>23.6</td>
<td>11.9</td>
</tr>
<tr>
<td>With primary education</td>
<td>46.0</td>
<td>15.8</td>
<td>7.5</td>
</tr>
</tbody>
</table>

% of poor population 100.0


Poverty is higher in households headed by persons who are elderly, uneducated, engaged in agriculture and/or reported being self-employed. As shown in Table 2.2, poverty incidence reaches 66 per cent for those living in households headed by agricultural workers – 8 percentage points higher than the overall poverty incidence in rural areas. Those living in poor farming households account for 68 per cent of the total number poor, and experience a poverty gap of almost 26 per cent. As most small farmers work for themselves, there is some overlap with household heads falling in the category of self-employed. Over half the population living in households whose heads are self-employed (53 per cent) are poor and the poverty gap for this group is 20 per cent. These households account for 79 per cent of all poor, testifying to the scale and high level of deprivation of the informal sector in Angola. The IBEP

\(^9\) Squared poverty gap (Severity of poverty): This takes into account not only the distance separating the poor from the poverty line (the poverty gap), but also the inequality among the poor. That is, a higher weight is placed on those households who are further away from the poverty line.
found that two thirds of the economically active population is self-employed or reports engaging unremunerated family work; in rural areas this proportion reaches 87 per cent compared to 44 per cent in urban areas.

Box 2.1 Vulnerability and deprivation in the peri-urban slums of Angola

Rapid urbanization has led to the growth of huge informal settlements in and around all the major cities, and in particular around Luanda. A study on the land market in Luanda (World Bank and DW 2011) found that three quarters of the capital’s population of almost 6 million live in peri-urban areas with weak tenure rights, making this population vulnerable to eviction and sudden loss of assets, while also being unable to use property as collateral to obtain bank credits for housing improvements or the development of small business. Only 8 per cent of households in the informal settlements (known as musseques) of Luanda have any official document providing legal evidence of tenure.

Urban population growth (estimated at 4.5 per cent a year during the period 2005-2010) has meanwhile put intense pressure on urban social infrastructure and services as well as on urban labour markets, in addition to presenting major environmental challenges. As pressures mount with continued urban growth, so do the implications for future social stability.

Safe drinking water is not widely accessible in peri-urban slums. A survey by the Urban Poverty Network, a group of NGOs working to improve living conditions in Luanda, found that 70 per cent of households in the municípios of Cazenga, Cacuaco, Viana, Kilamba Kiaxi and Sambizanga relied on water sold from private tanks and cistern trucks, as very few households in these areas are connected to the piped water supply. The water sold from tanks and cistern trucks comes from the Bengo River, and is often untreated, posing serious health risks (see Section 4.5). There is extreme inequity in the market for water, with informal market prices many times higher than the official subsidized tariffs charged for piped water to the more affluent areas. Prices in the bairros of southern Luanda farthest from the Bengo River are especially high (Cain & Mulenga 2009). Sanitation is also poor in these areas, since very few households are connected to the sewerage system and high population density exacerbates the risks of epidemics.

Social services have been overwhelmed by urban population growth and are particularly inadequate in the newest and fastest growing peri-urban areas. Urban schools are heavily overcrowded and often located far from recently developed informal settlements. The same is true for health facilities (see Section 4.2). In these areas, the poorest families often send their children to informal schools (known as explicações) and resort to private health providers operating in the unregulated informal market.

Labour markets are also overwhelmed by the ever-expanding supply of mainly unskilled labour which has forced wages down and swollen the informal sector. According to IBEP data, 44 per cent of the economically active urban population is self-employed or engaged in unremunerated family work. This proportion may be much higher in peri-urban areas where large numbers of children are engaged in labour. Due to intense competition, earnings in the informal economy are low and work is often sporadic.

Informal social protection mechanisms based on extended family obligations, community solidarity and reciprocity, have eroded in urban settings. Although many households include members outside the nuclear family unit, including children, there appears to be considerable instability within families and a high proportion of female-headed households due to separation and divorce. Single mothers are often left to raise their children with little or no support from fathers.

2.4 Rural vulnerability and climate change

The scale and depth of rural poverty stand in sharp contrast to the country’s significant agricultural potential. Section 2.2 discussed how poverty is both more widespread and more entrenched in rural areas, particularly for households dependent on agriculture for their livelihoods. Two thirds of households headed by farmers are poor and their average per capita consumption is 25 per cent below the poverty line, however Angola’s agriculture sector has the potential to be one of the most productive in Africa. The country possesses extensive areas of unexploited arable land and the advantages of low rural population density and a generally favourable climate for cultivation. The mix of diverse agro-climatic zones, ranging from the tropical humid north to the more arid south, with particularly good rainfall and soils in the western
high plateau, made Angola one of the premier agro-food exporters in Africa up to the 1970s. At this time the agriculture sector depended heavily on commercial agriculture and structured marketing mechanisms, both of which collapsed during the civil war. With the demise of large-scale commercial agriculture and urban population growth, Angola evolved from being a net food exporter to a massive net food importer. Angola currently produces approximately 1 million tons of cereals, less than half of the estimated 2.4 million tons required nationally (UN 2013).

Angola’s small farmers rely on shifting cultivation techniques that have low levels of productivity and contribute to food insecurity and environmental degradation. Although commercial agriculture is being revived and is a main focus of government agricultural policy, small-scale farmers dominate the sector, using traditional methods of rain-fed, shifting cultivation, with few external inputs (e.g. fertilizer, pesticides and improved seeds) to farm small plots of 2-3 hectares. This type of farming is highly vulnerable to drought and extreme weather, causes environmental damage as a result of slash-and-burn techniques and short fallow periods for soil regeneration, and has very low yields (Sykes 2013). Many rural households are at risk of food insecurity, particularly during the ‘lean season’ before harvests. Deforestation, which is a consequence of both shifting agriculture and high demand for wood and charcoal for fuel, contributes to environmental degradation. The Land Law (no 9/2004) provides some protection against arbitrary land expropriation and eviction, but rural populations with customary land tenure rights in the more fertile and geographically accessible areas are vulnerable to encroachments by commercial interests. Land enclosures by commercial ranchers in the Southwest likewise threaten the livelihoods of semi-nomadic pastoralists. Access to the land registration and justice systems is very difficult for poor rural populations while agricultural policy focuses more on promoting large-scale commercial agriculture than on developing the productivity of small family farmers and herders (Sykes 2013). A balance must be struck to promote productivity in the agricultural sector while protecting the interests of small farmers, their families and the environment.

Climate change exacerbates vulnerability in rural areas. Although Angola’s climate is generally favourable for agriculture as compared with many other parts of Africa, the country is not immune to the adverse effects of global warming. A study of long-term climatic trends by geographers at the University of Oxford for the UNDP found that mean annual temperature in Angola increased by 1.5oC between 1960 and 2006, an average of 0.33oC per decade, while mean annual rainfall decreased at an average rate of 2 mm per month (2.4 per cent) per decade over the same period, particularly affecting the latter part of the rainy season (March-April). 22

Climate change may also contribute to the increased frequency of extreme weather events such as droughts and floods. Severe droughts between 2011 and 2013 decimated harvests and increased food insecurity in much of southern and central Angola. According to an assessment in May-June 2013, the drought affected approximately 1.8 million people, of whom 700,000 were at risk of food insecurity (UN 2013). Flooding is another serious risk affecting the major river basins, especially in southern Angola. In 2008, floods in Huíla and Cunene made 30,000 people homeless. Natural disasters compound the existing problems with low agricultural productivity and seasonal food insecurity and have serious implications for the wellbeing of children in rural areas. These children may face acute under-nutrition linked to food insecurity particularly during drought periods, epidemics, damage to social infrastructure as a result of floods, and may experience disruption of their education due to temporary migration or other destabilizing events. In 2012 and 2013, lost cereal and legume production reached nearly 100 per cent in some areas of Cunene, Namibe, Benguela, Kwanza Sul and southern Huíla, and 40 per cent in northern Huíla. The crisis led to a surge of acute under-nutrition in young children, requiring a rapid emergency response.23 These vulnerabilities require ready capacity for disaster risk management, both to implement preventive measures including climate adaptation, and to mount a quick response to emergencies.

20 Angola was once the world’s fourth largest producer of coffee and also exported sisal, sugar and cotton.
21 Shifting agriculture is a system of cultivation in which a plot of land is cleared and cultivated for a short period of time, then abandoned and allowed to revert to producing its normal vegetation while the cultivator moves on to another plot. (OECD).
22 See McSweeney C, New M & Lizcano G, UNDP climate change country profiles: Angola, http://country-profiles.geog.ox.ac.uk. Rainfall, which is related to the seasonal oscillation of the Inter-Tropical Convergence Zone, is almost entirely concentrated in the period between October and April.
23 See Chapter 4, Section 4.3.
2.5 Governance

Harnessing Angola’s resources to improve the infrastructure and services necessary for economic diversification and human capital development requires major institutional reforms to strengthen governance. These include strengthening the justice system to improve law enforcement and the protection of rights, deepening democratic processes particularly for improved local governance, and reforms in public financial management to enhance transparency and accountability in the use of public resources. This analysis does not permit an in-depth discussion on these issues but two areas merit particular attention: (1) the limited scope of decentralization and (2) weaknesses in public financial management.

As part of a process of deconcentration, certain government functions and expenditures have been moved from national to sub-national administrative levels; however, democratic checks and balances are not yet established at sub-national levels. The present system of sub-national administration is essentially one of administrative deconcentration under which most local administrative functions are delegated to the 18 provincial governments and within the provinces to 156 municipal and 560 communal administrations. Law no 17/10 on the “organization and functioning of the local administration of the State” defined the provincial government as “a deconcentrated organ of the central administration whose purpose is to ensure that the functions of the Executive are carried out in the province.” The communal administrations answer to the municipal administration, which in turn answers to the provincial government. The pivotal figure in this system is the provincial governor who is appointed by and answerable to the President of the Republic. The provincial governor appoints municipal and communal administrators and there are currently no elected government structures at provincial, municipal or communal levels. According to decree-law no 02/07, consultative bodies, known as the Conselhos de Auscultação e Concertação Social (CACS), were established in some areas, but these are also nominated bodies and have no decision-making powers. Accountability to local populations is therefore quite weak. There is a provision, first included in the Constitutional Revision Law in 1992 and repeated in the 2010 Constitution, for the establishment of autonomous elected municipalities (autarquias), however it has not been implemented and it is not yet known when these bodies will be set up, what territorial scope they will have and what powers and resources they will be given.

The particular approach to deconcentration in Angola resulted in line ministries having somewhat limited authority over sub-national administrative bodies. Accountability is unidirectional, moving upward from communal and municipal administrations to provincial governments and from provincial governments to the Ministry of Territorial Administration (Ministério da Administração Territorial or MAT) and the Presidency which retains the power to hire and fire provincial governors. A key change in the 1990s was the conversion of the old ‘provincial delegations’ of the central ministries into ‘provincial directorates’ which answer to the provincial governors. At municipal level, sectoral ‘repartições’ play a similar role, functioning as integral units of the municipal administration. Most of the line ministries, including those for education, health and social assistance, retain the mandate for overall policy, norms, regulations and monitoring, and for some investments. However, since the provincial directorates and repartições municipais obtain their financial resources through the provincial governments and municipal administrations (in principle on the basis of provincial and municipal budgets), rather than through sector budgets, the line ministries exert little influence in practice.

---

24 This system has changed only slightly under successive decrees and laws on the matter, namely decrees no 17/99 and 29/00, decree-law no 02/07 and law no 17/10.
25 Law no 17/10, Article 10.
26 For an analysis of the role of the CACS in practice, see Pestana N and Orre A, Visão panorâmica sobre o processo de descentralização em Angola, undated paper.
27 The shift from provincial delegations to provincial directorates was made systematic in decree no 29/00 and restated in law no 17/10 excluding only the provincial delegations of the Ministries of the Interior, Finance and Justice.
28 Law no 17/10 states in article 34, that “the provincial directorate depends organically, administratively and functionally on the Provincial Government” and that “the specialized areas of the Central Administration provide methodological and technical support to the Provincial Directorates through the respective Provincial Governor”. By contrast, according to article 40, the provincial delegations of the Interior, Finance and Justice operate under a system of ‘double subordination’, under which they are administratively and methodologically dependent on the central ministry and functionally dependent on the provincial government.
29 The communal administrations are not budget units and so their allocations are integrated in the municípios’ budgets (article 84 of law no 17/10).
Sub-national administrative bodies have very weak capacity, especially outside the provincial capitals. According to government sources, 79 per cent of government staff at sub-national level work in the provincial capitals, 19 per cent in the municipal administrations and only 1 per cent in the communal administrations (MINPLAN 2010). On the whole, government personnel at sub-national level have low educational qualifications: only three percent have the status of técnicos superiores as graduates of higher education, and almost all of these (97 per cent) are based in the provincial capitals.

It is important to continue to enhance the quality of public financial management in Angola to build on recent progress in maintaining overall macro-economic stability. Key priorities in this area include the incorporation of all extra-budgetary resource flows into a unified state budget system, the development of a medium term fiscal framework for effective policy-based budget planning and strengthened procedures for the evaluation of public investment projects.

A sound medium-term expenditure framework (MTEF) is urgently needed to improve investment planning. Angola has lagged behind other developing countries in introducing an MTEF as a tool for medium-term budget planning. MTEF are essential planning tools in all sectors, including those related to children’s rights. Sound MTEF allow governments to prioritize expenditures and plan multi-year public investments with adequate provision for future recurrent costs. The first step towards an effective MTEF was the inclusion of a five-year macroeconomic scenario in the 2013 budget. The IMF has recommended that the development of an MTEF should be accompanied by steps to strengthen procedures for appraising investment projects and to consolidate the implementation of programme-based budgeting which links expenditures to planned results (IMF 2014).

2.6 The legal and policy framework for child rights

Angola has made substantial progress in establishing a stronger legal framework for child rights, however few political and legal commitments have been fully translated into real programmes and protections. Angola has ratified the main international legal instruments on child rights, including the CRC in 1990 and two optional protocols addressing the involvement of children in armed conflicts, the sale of children, child prostitution and child pornography. Angola has also ratified the African Charter on the Rights and Welfare of the Child31 and ILO Convention 182 concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour. Other relevant international conventions ratified by Angola include the Convention on the Rights of Persons with Disabilities ratified in 2012 and the Convention on the Elimination of All Forms of Discrimination against Women ratified in 1986. Angola has not yet ratified the 3rd Optional protocol of the CRC on the establishment of an individual complaints procedure32 nor the Palermo Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children. It is noteworthy that the 2010 Constitution includes articles that make strong commitments to children’s rights.33

30 For many years the national oil company SONANGOL, has carried out large quasi-fiscal operations (QFOs). There have also been long delays in transferring revenue due from SONANGOL to the Treasury. These practices have been a matter of concern (see IMF 2012 & 2014) and could be addressed by the full implementation of recent reforms intended to eliminate QFOs and ensure timely payment of oil revenues by SONANGOL to the Treasury.
31 Like the CRC, the Charter is a comprehensive instrument that sets out the rights of children and related principles and norms.
32 This protocol provides two ways for children to challenge violations of their rights committed by States: first, a communication procedure which enables children to bring complaints about violations of their rights to the UN Committee on the Rights of the Child (the body that monitors States’ compliance with their obligations under the CRC) and second, an inquiry procedure for grave and systematic violations of child rights.
33 Article 35 of the Constitution states that “the protection of the rights of the child, namely the child’s rounded and harmonious upbringing and the protection of the child’s health, living conditions and education, constitute an absolute priority of the family, the State and society”. Articles 77 and 79 affirm the right to health care, including specifically for maternal and child health care, and the right to education, while article 80 upholds the right of the child to the “special attention of the family, society and the State”, which, together, “must ensure the child’s full protection against all forms of abandonment, discrimination, oppression, exploitation and abusive exercise of authority in the family and in other institutions”. This article also incorporates one of the core principles of the CRC, on the best interests of the child, and makes special reference to the duty of the State to provide special protection to orphans, children with disabilities, abandoned children and all children deprived of a normal family environment.
The adoption of the Children’s Act in 2012 was a major step towards the incorporation of the rights and principles of the CRC and the African Charter into Angolan law. It complements protective legislation in specific fields, such as the Family Code (law no 1/88), the Labour Law (law no 2/00), the Adoption Law (law no 7/80), the Basic Law on Social Protection (law no 7/04), the Law against Domestic Violence (law no 25/11) and the Law on Juvenile Justice (law no 9/96), among others. The Children’s Act represents an important advance by providing for the first time an integrated, holistic framework for child rights in Angola. It spells out these rights and the corresponding obligations of duty bearers in many different fields, specifying in particular the services that the State must provide to fulfil these rights. The Act is particularly strong in upholding social rights pertaining to the survival and development of the child and sets out detailed obligations on the State to provide core minimum services, including for early childhood education, water and sanitation, child nutrition, birth registration and HIV/AIDS prevention, treatment and care. The Act also includes a wide range of protection rights addressing abduction, violence and abuse, harmful exposure to the internet, alternative care and juvenile justice, and affirms the principle of the best interests of the child. Particular attention is given to the rights of children with disabilities.

The Children’s Act provides a firm foundation for the realization of child rights; however some crucial provisions are still missing. The nature of the Children’s Act is that of a ‘framework law’ and the Act does not provide sufficiently detailed provisions in some areas. Specifically the Act does not provide adequate details regarding duty-bearers’ obligations, procedures to ensure rights are upheld or the sanctions to be applied to those responsible for violations. The Act also has some inaccuracies: for example, while it indicates that the views of the child should be given due consideration and weight (according to the child’s age, maturity and stage of development) on all matters concerning the child (including any judicial and administrative proceedings) it places the principle of child participation – one of the pillars of the CRC – as a duty instead as a right. Other key provisions missing from the Children’s Act include: (1) the prohibition of the worst forms of child labour; (2) the prohibition of the recruitment of children into the armed forces, the police or militias; (3) the regulation of non-institutional forms of alternative care such as adoption and fostering; (4) the prohibition of child marriage, with no exceptions including under customary law; (5) the prohibition of the use of children in begging; (6) the protection of children’s inheritance rights; and (7) the right to social security, including provisions for social assistance to guarantee a minimum standard of living and reduce vulnerability. The Act’s provisions are ambiguous on some topics such as corporal punishment of children, which is not explicitly prohibited, and very general on the issues of child trafficking and children in the justice system. Finally, the act does not clearly articulate the components and procedures of a child protection system, including the duties and responsibilities of key actors such as social welfare offices, the police, the judicial system and other service providers and related referral mechanisms.

The Act incorporates the ‘11 Commitments for Children’, which were adopted by the Government in 2007 as the core of a national agenda for children. Revised in 2011, the ‘11 Commitments’ concern child survival, food security and nutrition, birth registration, early childhood education, primary education and vocational training, juvenile justice, HIV/AIDS, violence against children, social protection and family competencies. The commitments also address the media, culture and sports, and the planning and budget system (CNAC 2011). The commitments provide a general framework for advancing the rights of children in each of these domains but have yet to be translated into concrete action through national planning, budget processes and/or through the management of programmes and services. Recommendations to operationalise these commitments are discussed sector by sector in later chapters of this report.

The National Council for Children (CNAC), set up in 2007, acts as a consultative, multi-sector body to monitor public policies for the promotion and defence of children’s rights and specifically the implementation of the Children’s Act. The Council includes representatives of a number of ministries and public agencies, professional associations, NGOs, churches and other civil society bodies, and four children representing children’s organizations. CNAC’s main activity is the organization of a series of national children’s forums, which have been held biannually since the Council’s creation. Through these forums, CNAC has been instrumental in promoting the 11 Commitments and raising the profile of child rights in the public policy discourse.

34 Law no 25/122 on ‘Proteção e Desenvolvimento Integral da Criança’ (Protection and Development of the Child) was adopted in 2012.
35 Article 6 upholds the principle of the best interests of the child, highlighting its primacy in disputes involving the child and in situations where two norms are in conflict.
36 For a detailed analysis of the Angolan Children’s Act, see Sloth-Nielsen, 2013.
Chapter 3.

Equity: To what extent is progress in social and economic development enjoyed by all?

This chapter is presented in two parts: the first provides an overview of Angola’s performance in the realisation of child rights compared with other countries in sub-Saharan Africa while the second examines equity of social development within Angola. As previously mentioned, in 2012 Angola was reclassified by the World Bank as an upper-middle income country. This classification is based on per capita GNI but does not reflect the status of the country’s social development. It is hence useful to understand how Angola fares on social indicators compared to other countries in the same income group. Given that Angola’s economic prosperity is relatively recent and social development inherently progresses at a slower pace, this analysis look towards other upper middle-income countries as a benchmark for what can be achieved in Angola with greater resources over time, while also referencing regional and global data for a broader perspective.37

The second part of this chapter compares different population groups within Angola to analyse equity in social and economic development and to identify especially disadvantaged groups in Angolan society. The analysis uses a limited number of headline indicators to illustrate internal disparities across urban and rural populations, gender, and household wealth, highlighting that the benefits of economic and social development are not enjoyed equally across the population. A more detailed sector-by-sector analysis follows in Chapters 4-6.

3.1 Comparing Angola’s performance to other upper middle-income countries in Sub-Saharan Africa

Angola’s performance on social development indicators is mixed when analysed against Sub-Saharan Africa (SSA) as a whole and lagging when compared to other African countries in the upper middle-income bracket. Angola is far wealthier than most SSA countries, with gross national income (GNI) per capita of US$5,010 in 2013, compared with an average of US$1,615 for Sub-Saharan Africa as a whole.38 In 2012, Angola joined the group of upper middle-income countries, currently defined by the World Bank as those with a GNI per capita falling in the range of US$4,126 to $12,745.39 Besides Angola, there are five upper middle-income countries in Sub-Saharan Africa: Botswana, Gabon, Mauritius, Namibia and South Africa. These countries all have a higher GNI per capita than Angola, ranging from US$5,840 to $10,650 in 2013, but they set standards to which Angola can aspire with its growing resources. To match the long-term social and economic performance of wealthy countries in Africa and beyond, Angola must make real investments in human capital starting during childhood.

Child survival

Under-5 mortality – the most significant indicator of progress on child rights and broader socio-economic development – remains very high in Angola. The 2008-2009 IBEP estimated the under-5 mortality rate (U5MR)40 at 194 deaths per 1,000 live births. Infant mortality was estimated to be 119 deaths per 1,000 live births. Model-based estimates generated by the Inter-Agency Group for Child Mortality Estimation (UN-IGME) indicate that by 2013, U5MR declined to 167 and the infant mortality rate to 102. The UN-IGME estimates are based on projections from the IBEP 2008-2009 which was the last national

37 See also Table A.1 in Annex A for comparisons across a wider range of indicators.
38 GNI per capita data are from the World Bank, World Development Indicators, accessed at data.worldbank.org
39 This range reflects the current criteria for upper middle-income classification. When Angola was classified as an upper middle-income country for the first time in 2012, the upper middle-income range was US$4,086 to $12,615.
40 Under-5 mortality rate and infant mortality rate are measured as deaths per 1,000 live births.
survey to collect mortality data in Angola. The UN-IGME estimate for U5MR in Angola is approximately two thirds higher than the average for Sub-Saharan Africa which includes many countries that are far poorer than Angola and/or have been affected by war. Among SSA upper-middle income countries, Angola is an extreme outlier; U5MR in these countries ranges from 15 in Mauritius to 62 in Gabon (See Figure 3.1).

**Nutrition**

Child under-nutrition rates in Angola are comparable to those for other upper middle-income countries. The prevalence of stunting – the result of chronic under-nutrition – was last estimated in the 2007 National Nutrition Survey at 29 per cent in Angola, compared with a global average of 25 per cent and an SSA regional average of 38 per cent. The rate of stunting in other SSA upper-middle income countries ranges from 17 per cent in Gabon to 33 per cent in South Africa (See Figure 3.1).

**Literacy**

Angola has made substantial improvements in adult literacy, however literacy remains low relative to other SSA upper-middle income countries, a disadvantage for further economic and social development. According to the most recent QUIBB data, just over two thirds of adults (69 per cent) are literate, a far smaller proportion than in the other countries in Angola’s income group (see Figure 3.1). Literacy is particularly low among women (57 per cent) as compared with men (82 per cent) in Angola, whereas all other countries in the upper middle-income group have achieved gender parity in literacy.

**Figure 3.1 Performance on key social development outcomes (literacy, nutrition and under-5 mortality): Where Angola ranks within the region, the world, and among upper middle-income Sub-Saharan Africa**


---

41 Data from Mauritius are not available for this indicator.

42 In fact in Botswana and Namibia, female literacy is slightly higher than male literacy.
Access to improved water and sanitation

Access to improved water sources has been expanded particularly in urban areas of Angola, but remains below the regional average and rates of access are significantly lower than in other upper middle-income countries. Just half (53 per cent) of the Angolan population uses improved water sources (i.e. sources protected from faecal or chemical contamination). This rate is 10 percentage points below the average for Sub-Saharan Africa and far worse than in all income group countries, where rates of access range from 88 per cent in Gabon to 100 per cent in Mauritius. Angola has slightly better rates of use of improved sanitation facilities, particularly in urban areas (see also Section 4.5).

Maternal and child health

While vaccination coverage is estimated to have increased in recent years, access to most maternal and child health services remains limited (see Section 4.2). Although malaria is the leading cause of death in young children and the number one health problem in Angola, available data shows very low use of preventive and curative interventions for malaria. According to the 2011 Malaria Survey, only 26 per cent of children under 5 in Angola sleep under insecticide-treated nets compared with the SSA regional average of 36 per cent. Similarly, only 28 per cent of children under 5 who are ill with fever receive anti-malarial drugs in Angola compared to 37 per cent across the whole of Sub-Saharan Africa (MIS 2011). There is also a large disparity between Angola and other SSA upper middle-income countries in access to maternal health services, captured as the proportion of births that take place in health facilities. Only 51 per cent of deliveries in Angola take place in health facilities – slightly higher than the average for Sub-Saharan Africa (48 per cent) but very low for upper middle-income countries. Among other SSA upper middle-income countries, the proportion of births taking place in health facilities exceeds 80 per cent and is close to 100 per cent in Mauritius and Botswana (See Figure 3.2). Lifetime risk of maternal death in Angola is 1 in 35 as compared with 1 in 94 in Gabon, less than 1 in 200 in Botswana, Namibia and South Africa, and 1 in 900 in Mauritius (WHO 2014). Improvement of the availability, use and quality of maternal health services, with particular focus on increasing the proportion of births that take place in health facilities, is crucial to reduce both maternal and neonatal mortality in Angola.

Due in part to low use and poor quality of antenatal services, Angola has a much lower rate of coverage of HIV-positive pregnant women with antiretroviral prophylaxis to prevent mother-to-child transmission of HIV (PMTCT) than other countries in its income group. PMTCT coverage in Angola was 39 per cent in 2013, compared with 70 per cent in Gabon, 83 per cent in South Africa and more than 90 per cent in Botswana and Namibia. With an adult HIV prevalence rate of 2.3 per cent, Angola has so far been spared an HIV/AIDS epidemic on the scale seen in other Southern African countries, however low coverage of prevention and treatment services leaves no room for complacency. Angola is the only one of 22 priority countries identified in the Global Plan Towards the Elimination of New Infections Among Children in which the number of new HIV infections among children has continued to increase. New infections among children increased by a cumulative 9 percentage points from 2009-2012 (see Section 4.4).

43 Comparisons with the other middle-income countries are not meaningful since most are not in endemic malarial areas or have succeeded in eradicating malaria.

44 Lifetime risk of maternal death is the probability that a 15-year-old female will die eventually from a maternal cause assuming that current levels of fertility and mortality (including maternal mortality) do not change in the future, taking into account competing causes of death.

45 In full, the Global Plan Towards the Elimination of New Infections Among Children by 2015 and Keeping Their Mothers Alive was developed through a consultative process under the leadership of UNAIDS.
Figure 3.2 Coverage of maternal and child health services and improved water and sanitation: Where Angola ranks within the region and among upper middle-income Sub-Saharan Africa


Education

Angola has made significant progress in expanding access to primary education, but greater investment in the quality and accessibility of education is required to close the gap with other SSA countries in the upper middle-income group. In recent years Angola has seen a large and rapid increase in absolute pupil numbers; however rates of late entry into primary school, high repetition and premature dropout contribute to a very low primary completion rate (see Section 5.5). The World Bank estimated that in 2010, less than half of students completed the last year of primary school (47 per cent) and the primary completion rate was even lower among girls (40 per cent). Recent data from the Ministry of Education (Ministério da Educação or MED) indicates a completion rate of 78.1 per cent at primary education level (MED 2014). By contrast, neighbouring Namibia achieved a primary completion rate of 85 per cent and in Mauritius primary completion reached 99 per cent in 2012. The primary net attendance ratio (NAR) for Angola (78 per cent for girls and 80 per cent for boys) is above the average for Sub-Saharan Africa but lower than in all the other upper middle-income countries in the region. At the secondary level, Angola’s performance lags behind the region as a whole. Secondary NAR in Angola is just 27 per cent for girls and 29 per cent for boys, 5 percentage points below the averages for Sub-Saharan Africa and considerably less than in other upper middle-income countries (see Figure 3.3).
Figure 3.3 Access to education: Where Angola ranks on net attendance rates in primary and secondary school within the region and among upper middle-income countries in Sub-Saharan Africa

<table>
<thead>
<tr>
<th>Country</th>
<th>Primary net attendance ratio</th>
<th>Secondary net attendance ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>81% 83%</td>
<td>51% 55%</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>71% 73%</td>
<td>23% 24%</td>
</tr>
<tr>
<td>Namibia</td>
<td>93% 91%</td>
<td>47% 50%</td>
</tr>
<tr>
<td>Gabon</td>
<td>87% 86%</td>
<td>58% 53%</td>
</tr>
<tr>
<td>Botswana</td>
<td>88% 88%</td>
<td>44% 36%</td>
</tr>
<tr>
<td>Angola</td>
<td>78% 80%</td>
<td>27% 29%</td>
</tr>
</tbody>
</table>


3.2 Equity in key outcomes and access to basic social services

There are large geographic disparities, in particular between urban and rural areas and between the coast and the interior. Historically, economic and social development in Angola has been concentrated in the coastal areas and along the railway corridors into the interior. Most of the rest of the interior, in particular in the east of the country, has suffered from limited access to transportation routes, markets and public services. Geographic disparities widened during the war when internal communication became increasingly difficult across much of the interior and public services collapsed in rural areas. Large portions of the rural population migrated to cities, particularly those along the coast. Although the Government has made substantial efforts to expand and rehabilitate transport infrastructure, markets are not well developed and some public services such as secondary schools, health facilities and civil registration offices have not yet reached many parts of the country. Due to the huge growth of the urban population and limited urban planning and provision of services, there are also large disparities in social development between the core urban areas and the slums in the peri-urban areas (see Box 2.1 in Chapter 2). Unfortunately, national surveys do not provide for the disaggregation of data between urban and peri-urban areas so a detailed analysis of disparities on key development indicators is limited to urban and rural comparisons (see Figure 3.4).

46 Large coastal cities include Luanda, Benguela and Lobito. Major cities along the railway corridors include Huambo and Lubango.
47 Table A.2 in Annex A provides data on urban-rural disparities for a wider range of indicators.
Rural areas are worse off than urban areas on all social development indicators, and in some sectors such as water and sanitation, secondary education, literacy, maternal health and child survival, the disparity is significant. Children in rural areas are one and a half times more likely to die before the age of 5 than children in urban areas (IBEP 2008-2009). According to the 2011 QUIBB, only a quarter of rural births take place in health facilities, compared with three quarters in urban areas. The QUIBB also found rates of child labour (among children aged 10-17) were almost four times higher in rural areas. A national malaria survey in 2011 found that the proportion of children under 5 with fever receiving antimalarial drugs in rural areas was half that in urban areas where still less than 50 per cent received treatment. The estimated proportion of the population using improved water sources for drinking in rural areas is only about half the level in urban areas and the proportion using improved sanitation facilities is just over one fifth that in urban areas.\(^48\) Rural areas of Angola are significantly disadvantaged in education, especially in secondary education: Secondary NAR is more than five times higher in urban than in rural areas and adult literacy is twice as high in urban areas (QUIBB 2011).

Large inequities in child and human development are also associated with household wealth, although certain indicators show that even the ‘richest’ households may experience high levels of deprivation. Figure 3.5 uses a selection of headline indicators to illustrate how child and human wellbeing increase with household wealth.\(^46\) In some cases, the differentiation among wealth quintiles is quite sharp.\(^50\) When interpreting associations between wealth and wellbeing, it is important remember that there is a considerable overlap between the urban-rural and inter-quintile distributions of the population, as the overwhelming majority of the rural population fall in the two poorest wealth quintiles (83 per cent) as compares to just 14 per cent of the urban population (QUIBB 2011).

\(^{46}\) WHO/UNICEF Joint Monitoring Programme estimates.

\(^{48}\) See Table A.3 in Annex A for data on a wider selection of indicators by wealth quintiles.

\(^{50}\) The wealth index is a measure of household wealth constructed from survey data on households’ land, housing and other assets, to group the household into five groups of equal size, or ‘quintiles’, rising from the poorest to the richest. Thus, the 1st quintile (Q1) is the poorest 20 per cent of the population, while the 2nd quintile (Q2) is the second poorest and so on, up to the 5th or richest quintile (Q5).
Box 3.1 Household wealth and inequities in child and human development indicators

Water and sanitation
A large majority of the population in the poorest quintile (Q1) uses unsafe surface water sources such as rivers and lakes to obtain water for drinking and resorts to open defecation in the bush. The use of unsafe water sources decreases with increased wealth: a third of the population in the second quintile and about a fifth in the third quintile still use unsafe surface water as compares to less than 5 per cent in the richest two quintiles.

Access to health services
There are large wealth-related disparities in the use of health services. Pregnant women in the richest quintile are 2.4 times more likely to have 4 or more antenatal consultations and over 4 times more likely to deliver in a health facility, compared with pregnant women in the poorest quintile. Children under 5 in the richest quintile are 2.9 times more likely to sleep under an ITN and 2.4 times more likely to receive antimalarial treatment when they are ill with fever than children in the poorest quintile. However, even in the richest quintile, just over one third (34 per cent) of children under 5 sleep under an ITN and 42 per cent receive antimalarial treatment when ill with fever.

Education
Disparities in education across wealth quintiles are most extreme at the secondary level. The primary net attendance ratio (NAR) increases progressively from 67 per cent in the poorest quintile to 89 per cent in the richest quintile, although it is notable that even in the wealthiest households, 11 per cent of children aged 6-12 do not attend primary school. Disparities are much larger in secondary education, partly reflecting the concentration of secondary schools in urban areas. Only 4 per cent of children aged 12-18 in the poorest quintile attend secondary school, compared to 8 per cent of those in the second poorest quintile and 57 per cent in the richest quintile. It is not surprising that adult literacy follows a similar pattern: adults in the richest quintile are more than twice as likely to be literate as those in the poorest (87 per cent compared to 41 per cent).

Child survival
While under-5 and infant mortality is slightly higher in poorer households, mortality rates are high across all wealth groups and relative differences are quite small. Shallow variation in child mortality across wealth quintiles is not unusual in low-income Sub-Saharan African countries, but would be less typical in an upper middle-income country like Angola. Relatively small variation suggests that health and environmental conditions are generally poor, affecting all households regardless of wealth. It is possible that under-nutrition and micronutrient deficiencies – important determinants of child survival – are high across all quintiles. However this relationship cannot be explored as existing nutrition data cannot be disaggregated by household wealth.
Angola has achieved parity at the primary school level in female to male net attendance ratios (QUIBB 2011); however, administrative data shows that dropout rates appear to be higher among girls than boys, resulting in a lower rate of primary completion for girls.\(^5\) By secondary level a clear gender gap emerges: the gender parity index (GPI) for secondary NARS is 0.93. In other words, there is a 7-percentage point gap between the sexes in secondary NARS to the disadvantage of girls. The gap is particularly wide in rural areas, where GPI for secondary NARS is 0.54. However gender disparity in rural areas is overshadowed by the fact that so few children of either sex go to secondary school; only 11 per cent of boys and 6 per cent of girls aged 12-18 in rural areas attend secondary school.

\(^{5}\) Data on dropout and completion rates are drawn from administrative sources and generally considered unreliable (see Chapter 5).
Orphan status and disability are further dimensions of disadvantage and inequity in childhood. Children who have lost both their parents (double-orphans) have lower school attendance than non-orphans. The IBEP 2008-2009 survey found that 74 per cent of double orphans aged 10-14 were in school, 12 percentage points less than for all children in this age group. Girls were found to be especially vulnerable: only 64 per cent of double-orphan girls in this age group were attending school. Children with disabilities are another highly vulnerable group facing social isolation and discrimination as well as the disadvantages of diminished functional capability. People with disabilities had far lower educational attainment than the rest of the population; almost one third of people with disabilities had never been to school compared to one fifth of the general population. Females with disabilities suffer compounded disadvantages and almost half had never been to school (see Section 6.1).

Figure 3.6 Gender parity indices for education and literacy by rural and urban residence, 2011

3.3 Conclusions

This chapter shows that compared to other upper-middle income countries in the region, Angola is lagging in social development as measured by selected indicators. To some extent, this can be attributed to the fact that Angola’s economic development is relatively recent, and social development inherently takes more time to show improvement. To catch up with levels of social development in other countries in the upper middle-income group, Angola will need to maintain focus and increase investment in the social sectors.

At the national level, social development appears to be following economic growth, however available data show massive disparities in access to basic social services and health and educational outcomes among different population groups. Angolans living in rural areas and those in the poorest households and/or engaged in agriculture or the informal economy, are the worst off. Girls and women, orphans and people with disabilities experience added layers of disadvantage. In order to reduce inequality, there is a need to ensure that programmes and policies in social sectors explicitly tackle disparities. The following chapters of this report offer a more in-depth analysis of progress and equality in key sectors (health, education and protection) and provide specific recommendations for improving the equity and sustainability of socio-economic development in Angola.
Child Disciplinary Practices

© UNICEF/UNI155468/Shefita
Chapter 4. Ensuring children’s survival and health

As a signatory to the Millennium Declaration and the Convention on the Rights of the Child, the Government of Angola has made strong commitments to child survival, encompassing the rights to health care, adequate nutrition, and safe water and sanitation. The Constitution of the Republic of Angola, along with the 11 Commitments for Children and national legislation such as the Children’s Act (Law no 25/12), further enshrines these rights. Rights to the highest attainable standard of health, adequate nutrition and access to safe water and sanitation are not only individual entitlements but also preconditions for human development, poverty reduction and sustainable economic growth. Global estimates suggest that every 10 percentage point improvement in life expectancy at birth is associated with an increase in GDP growth of at least 0.4 percentage points per year, holding other growth factors constant (Sachs et al 2001). The reverse is also true that without minimum levels of health, countries cannot maintain high rates of growth in the long term (López-Casasnovas et al 2003). The close relationship between the health of the population and the long-term health of the economy is particularly relevant in Angola where oil revenues can finance sustainable investments.

Since the end of the war, Angola has made progress in improving children’s chances of survival; however child mortality in Angola remains high due to low access to essential health services, high rates of under-nutrition and micronutrient deficiencies, and unhealthy environments. Within the Angolan population, large disparities exist in health outcomes and access to health services and to clean water and sanitation facilities. The poor and those living in rural areas are disproportionately vulnerable to health risks and have lower access to services. This chapter presents an analysis of trends in child survival, equity in health outcomes and access to related services and information, and key determinants of health outcomes for children. Section 4.1 begins with an assessment of the trends, inequities and determinants of child and maternal mortality. Section 4.2 assesses the coverage of child and maternal health services, bottlenecks affecting the supply and quality of health services, demand-side access barriers and knowledge and behaviours that affect health outcomes. The remainder of the chapter provides more in-depth analysis of the situation for children and government responses in nutrition (Section 4.3), HIV/AIDS (Section 4.4) and water and sanitation (Section 4.5).

4.1 Child and maternal mortality

Child mortality in Angola is gradually declining, however far too many children continue to die before the age of five. Due to a lack of comparable data over time, child mortality estimates for Angola must be taken with caution but can still be regarded as indicators of the health and wellbeing of children and of society as a whole. Mortality rates are driven by a wide range of factors, including access to health care, safe water and sanitation, household income and food availability, child-feeding practices and the nutritional status of children. The most recent reliable national surveys with data on under-five and infant mortality are the MICS 2001 and the IBEP 2008-2009. The 2001 MICS estimated under-5 and infant mortality at 250 and 150 deaths per thousand live births respectively; most likely underestimates as the areas worst-affected by conflict were not accessible at that time and would logically have had even higher mortality rates. Accounting for the limitations of 2001 data as a baseline, the 2008-2009 IBEP shows a substantial decline in child and infant mortality to 194 and 116 deaths per thousand live births respectively. The UN Inter-Agency Group for Child Mortality Estimation (UN IGME) used existing data to model child mortality in Angola for 2013, estimating under-five mortality at 167, infant mortality at 102 and neonatal mortality at 42 deaths per thousand live births (See Figure 4.1). Assuming the UN-IGME estimates are roughly accurate, one in six Angolan children does not reach their fifth birthday. As Chapter 3 noted, these estimates place Angola among the worst performing countries in the world for child survival. Despite recent progress, Angola is still very far from achieving the MDG U5MR target of 75 deaths per 1,000 live births by 2015.

52 The 2015 MDG target is based on a two-thirds reduction in under-5 mortality since 1990. In 1990, the UN IGME estimated U5MR in Angola was 226 deaths per 1,000 live births.
Angolan children living in rural areas have a higher risk of dying than those living in urban areas. The 2008-2009 IBEP indicates that close to a quarter (23 per cent) of rural children die before the age of five, compared with 15 per cent of urban children.

No recent survey-based data on maternal mortality are available, but UN models have estimated the maternal mortality ratio (MMR) at 450 per 100,000 live births (WHO and UNICEF, 2010). Haemorrhages, puerperal infections, pre-eclampsia and eclampsia are the main direct causes of maternal mortality, and indirect causes include malaria, hepatitis and anaemia linked to deficiencies in mothers’ nutrition. Only 57 per cent of pregnant women make four or more antenatal care visits, and only about half of all births occur in a health facility (see Section 4.3.1). Poverty and socio-cultural practices resulting in early sexual debut, teenage pregnancy, inadequate birth spacing and high fertility contribute to the vulnerability of women during childbirth (see Section 4.3.3), while supply-side constraints limit access to health facilities and especially emergency obstetric services (see Section 4.3.2).

Malaria, diarrhoea and acute respiratory infections (ARI) account for the overwhelming majority of child deaths. Although there are no accurate statistics on the causes of mortality in young children in Angola, administrative data from the Ministry of Health indicate that malaria is the leading cause of child mortality, followed by diarrhoeal diseases, ARI and measles. All four of these diseases are preventable and treatable at low cost. Under-nutrition, which is discussed in Section 4.4, is a major underlying cause of child deaths.

In recent years, Angola has had several outbreaks of cholera, which can quickly reach epidemic level in conditions where sanitation is poor and water sources are unsafe. In 2013 there were over 5,300 notified cases of cholera, mainly in Cunene, with 184 deaths by the end of November (MINSA & OMS 2013). Although the disease was almost eradicated in Angola, polio has also emerged as a threat to children in past years. No new cases of wild polio virus have been detected since 2011 but there is a continuing risk of re-importation from India and across the northern border from the Democratic Republic of Congo (DRC) as occurred in 2005 and 2007-2011. UNICEF Angola’s 2013-2015 polio eradication strategy observed that “Angola’s experience with polio is a stark reminder that countries that have eliminated polio within their borders are not safe from a new polio outbreak until the entire world is free of this vaccine-preventable disease.”

---

53 Angola earlier succeeded in interrupting polio transmission in 2001. In 2010, 34 cases were reported and just 4 cases were reported in 2011.
Box 4.1 Causes of under-5 mortality in Angola

The leading causes of child mortality in Angola include malaria, diarrhoeal diseases, acute respiratory infections (ARI), and measles. Under-nutrition is an underlying cause of a large proportion of deaths in children under 5.

- **Malaria** accounted for 57 per cent of registered deaths of children under 5 in hospitals in 2011. In the population as a whole this disease accounts for about 35 per cent of demand for curative care, 20 per cent of hospital in-patients and 25 per cent of maternal mortality (MINSA 2012).

- **Acute respiratory infections (ARI)**, including pneumonia and influenza, are the third main cause of illness and mortality in young children. There are several types of ARI, but the most serious and common are caused by *Haemophilus influenza* and *Streptococcus pneumonia*, both of which can be prevented through vaccination. The current vaccination schedule already includes the vaccine for *Haemophilus influenza* (within the pentavalent vaccine) while a vaccine for *Streptococcus pneumonia* was introduced in 2013 (see below). The WHO estimates that every year in Angola there are 125,000 cases and 36,400 deaths from *Streptococcus pneumonia*, among children under 5.

- **Diarrhoeal diseases** are common due to widespread use of unsafe water sources and low coverage of improved sanitation facilities (see Section 4.5). In 2010, health facilities recorded 244,526 cases of diarrhoeal disease in children under 5. The WHO estimates that annually rotavirus alone causes 300,000 cases of diarrhoea and 21,300 deaths in children under 5.

- **Measles** contributes to child mortality during cyclical epidemics. In 2011, 13,115 measles cases and 436 deaths were notified during a measles outbreak mainly in children aged 1-4. It should be noted that these figures significantly underestimate the impact of measles as they depend on case notification which is quite weak in Angola due partly to poor coverage of health services in some areas. It is estimated that less than 60 per cent of known cases are notified and measles is often not registered as the cause of death in hospitals.

Neonatal complications are estimated to cause up to a fifth of child deaths, and could be greatly reduced if more births took place in health facilities and skilled community health workers were on hand to provide promotional, preventive and curative services during the first week of life (see Sections 4.2 and 4.3).

4.2 Child and maternal health care

This section assesses the coverage and quality of child and maternal health care. Following an analysis of the coverage of key child and maternal health services, two key determinants of coverage are examined: (1) the supply of health services including infrastructure, drugs and human resources and (2) factors affecting demand for health services such as health-related knowledge, attitudes and practices.

4.2.1 Key interventions

Child mortality from infectious diseases could be reduced substantially by scaling up simple preventive and curative interventions. These interventions include the use of mosquito nets, indoor spraying and timely and appropriate treatment for malaria, antibiotic treatment for ARI, improved water, sanitation and hygiene to prevent diarrhoeal diseases, and vaccinations against ARI, measles and other dangerous childhood diseases. Promotion of good nutritional practices, in particular exclusive breastfeeding during the first six months of life and adequate intake of vitamin A, are also critical and practical measures to protect children from the risks of infection (see Section 4.3). This sub-section focuses in particular on three vital components of child and maternal health care: immunization of children against vaccine-preventable diseases, prevention and treatment of malaria, and the provision and use of maternal health services.

While government officially promotes integrated approaches to health service delivery, these have not been applied in practice. Approaches such as the Integrated Management of Childhood Illnesses (IMCI) and Integrated Management of Pregnancy and Childbirth (IMPAC) are proven internationally to be the most
cost-effective ways to address child and maternal health needs. IMCI and IMPAC are incorporated in the National Health Development Plan 2012-2021 (Plano Nacional de Desenvolvimento Sanitário or PNDS). The PNDS prioritizes primary health care and building the case management skills of health-care staff, while strengthening the overall health system and improving family health practices through community-based promotional and preventive activities. Angola now faces the considerable challenge of roll-out, bringing the benefits of integrated approaches to the people who most need them.

Immunisation

New vaccines are being introduced through the Expanded Programme on Immunization (EPI). Until 2012, the EPI schedule in Angola included nine vaccines for children less than 1 year old: vaccines against BCG, polio (3 doses), pentavalent vaccine (diphtheria, pertussis, tetanus, hepatitis-B and Haemophilus influenza type b (Hib) in one vaccine delivered in 3 doses), measles vaccine, yellow fever vaccine, and tetanus toxoid vaccine for women of childbearing age. Vaccination against Streptococcus pneumonia - the primary causative agent of paediatric bacterial meningitis - was added in 2013 and in 2014 a vaccine for rotavirus - the primary cause of severe diarrhoea in children - was also introduced. These additional vaccines have the potential to dramatically reduce the incidence of ARI and diarrhoeal disease, contributing to a reduction in child mortality. Given weaknesses in the Angolan health system, it is important that the introduction of new vaccines is accompanied with adequate system strengthening to ensure they reach as many children as possible without further compromising overall functioning.

According to the 2008-2009 IBEP, less than a third of children aged 12-23 months were fully immunized, although more recent administrative data indicate higher immunization rates. In 2008, just 29 per cent of children aged 12-23 months received all the core EPI vaccines. Compliance with the vaccination schedule is problematic as demonstrated by declines in the coverage of successive doses of the DPT vaccine from 41 per cent for the first dose to 27 per cent for the third dose. Vaccination coverage showed large rural-urban disparities - 43 per cent of urban children aged 12-23 months were fully vaccinated compared with only 12 per cent of rural children. Full vaccination rates increased with household wealth, from 13 per cent of children aged 12-23 months in the poorest two quintiles to 55 per cent in the richest quintile. Vaccination rates also increased with the educational level of the child’s mother (IBEP 2008-2009). Ministry of Health data paint a different picture, showing substantially higher immunisation rates. Full coverage of pentavalent-1 vaccine was reported at 99 per cent for most of the period 2007-2011 while coverage of pentavalent-3 was reported to be 73-91 per cent depending on the year. Measles vaccination coverage during that period was reported in the range 77-93 per cent (compared with the IBEP estimate of 58 per cent). Mobile teams carried out about 25 per cent of routine vaccinations. The Ministry of Health reports that coverage is far below national averages in a number of remote areas far from health posts, due to lack of personnel, vehicles and cold chain equipment. It was reported that 23 municípios had DPT3 coverage below 50 per cent in 2011 (MINSA 2012).

Continued vigilance is essential to ensure Angola remains polio-free. Following an outbreak of polio cases in 2007-2011, the Government implemented an emergency strategy in 2011 that succeeded in interrupting polio transmission. The response included measures to prevent the re-importation of wild polio virus from the DRC, community awareness-raising activities and polio vaccination campaigns, along with controls and compulsory vaccination for persons crossing the border, and surveillance of acute flaccid palsy. Repeated national polio immunization days have been supported by UNICEF and WHO. It will be critical to ensure high coverage of routine immunization if Angola is to protect its polio-free status in the long-term.

---

54 Integrated approaches have a number of advantages over ‘vertical’ disease-centred approaches; by recognising the interaction between different diseases and between infection and nutrition, integrated approaches make it possible to employ scarce financial, human and infrastructure resources efficiently across a range of services. Further, the child receives a comprehensive assessment at the point of service, contributing to a considerable reduction in opportunity costs for mothers.

55 The full EPI schedule in 2008 included vaccines against BCG, polio (3 doses), DPT 3 (3 doses) and measles.
Prevention and treatment of Malaria

There has been a steady expansion of services for the prevention and treatment of malaria, but coverage still falls short in many areas and is subject to large geographic and socioeconomic disparities.

While the proportion of young children sleeping under insecticide-treated nets (ITNs) is progressively increasing, two thirds still are not protected this way. Though the comparability of survey data is questionable, estimates indicate that ITN coverage grew from 2.3 per cent in 2001 (MICS 2001) to 17 per cent in 2006 (MIS 2006/7) and 30 per cent in 2011 (QUIBB 2011). The trend is clearly positive however the vast majority of children under-5 still do not sleep under ITNs. Recent surveys capture large disparities in the use of ITNs: ITN coverage is far lower in rural areas and among poorer households (see Figure 4.2). The MIS 2007 shows that other preventive measures such as residual indoor spraying were used by just 7 per cent of households. Greater investment in preventive measures including ITNs and indoor spraying would not only save large numbers of young lives but also significantly reduce the huge burden that people affected by malaria place on the health system.

Figure 4.2 Percentage of children under 5 sleeping under ITNs by area of residence, wealth quintile and education level of household head, 2011

Timely and appropriate treatment for malaria is low and particularly sensitive to socio-economic and geographic inequities. Less than one third (29 per cent) of children under five with a fever received any antimalarial treatment in 2011, almost unchanged since 2007. Even fewer children received the recommended treatment, artemisinin-based combination therapy (ACT) the day on or the day after the onset of fever: 14 per cent according to IBEP 2008-2009 and 12 per cent according to the MIS 2011. The proportion of children receiving ACT rapidly after the onset of fever is particularly low in rural areas (7 per cent) and in the poorest wealth quintiles (3 per cent) (MIS 2011). There were also alarming disparities in treatment coverage between regions with different levels of malaria risk. A redoubled effort is needed to expand coverage of ACT so that all children irrespective of wealth or location receive timely and appropriate treatment (see Figure 4.3).

56 Malaria regions are defined as hyper-endemic, meso-endemic stable and meso-endemic unstable corresponding approximately with Angola’s humid northern, central and dry southern climatic zones.
Maternal health services

The Government promotes an integrated approach to reducing maternal mortality focused on strengthening maternal and neonatal health services at the municipal level through primary health care, community outreach and referral of mothers at risk to second-tier health facilities. The strategy aims to ensure that pregnant women have access to an essential package of maternal health services and that skilled personnel attend every delivery. These objectives have been achieved only to a very limited extent, especially in rural areas.

Coverage of maternal health services is increasing but remains low. Antenatal consultation rates have increased by 16 percentage points for one or more consultations and by 10 percentage points for four or more consultations between 2008 and 2011. However, only 57 per cent of pregnant women access the recommended four or more consultations. Likewise, while there has been some progress in increasing the proportion of deliveries in health facilities, from 42 per cent in 2008-2009 to 51 per cent in 2011, however half of all women continue to deliver at home (see Figure 4.4). (IBEP 2008-2009, QUIBB 2011)

There are also serious gaps in the quality of available maternal health services. For example, the proportion of pregnant women receiving intermittent preventive treatment for malaria during their pregnancy remains very low and hardly changed between surveys in 2008 (16 per cent) and 2011 (17.5 per cent). The percentage of women receiving 2 or more vaccinations against tetanus during their last pregnancy was 68 per cent in 2008, with no more recent data available. (IBEP 2008-2009, QUIBB 2011).

---

57 Intermittent preventive treatment is defined here as two or more doses of SP/Fansidar during pregnancy, including at least one dose during an antenatal consultation.
The QUIBB 2011 data shows very large inequities in the use of maternal health services between wealth groups and urban and rural populations (see Table 4.1). For example, the proportion of deliveries taking place in health facilities is only 20 per cent in the poorest quintile as compared to 87 per cent in the richest quintile, and 74 per cent in urban areas compared to 25 per cent in rural areas. In short, three quarters of rural women do not deliver in health facilities. The same pattern is seen in deliveries attended by skilled personnel. Furthermore, a quarter of pregnant women in rural areas do not attend any antenatal consultations, compared with 6 per cent in the urban areas, and only 41 per cent in rural areas attend the recommended four or more consultations compared with 71 per cent in the urban areas. Disparities are even more striking across wealth quintiles: women in the richest quintile are more than four times more likely to deliver in health facilities than women in poorest quintile – more than a fifth of whom receive no antenatal care at all.

Table 4.1 Use of maternal health services by residence, educational level of household head, and wealth quintiles, 2011

<table>
<thead>
<tr>
<th></th>
<th>% of deliveries in health facilities</th>
<th>% of deliveries assisted by health personnel</th>
<th>1+antenatal consultation (% pregnant women)</th>
<th>4+antenatal consultations (% pregnant women)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>74.0</td>
<td>75.7</td>
<td>94.4</td>
<td>71.2</td>
</tr>
<tr>
<td>Rural</td>
<td>25.2</td>
<td>35.2</td>
<td>76.6</td>
<td>41.4</td>
</tr>
<tr>
<td><strong>Education of HH head</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>35.9</td>
<td>42.5</td>
<td>81.3</td>
<td>47.4</td>
</tr>
<tr>
<td>Primary</td>
<td>72.5</td>
<td>79.6</td>
<td>93.7</td>
<td>73.3</td>
</tr>
<tr>
<td><strong>Secondary+</strong></td>
<td>90.8</td>
<td>91.0</td>
<td>96.5</td>
<td>79.4</td>
</tr>
<tr>
<td><strong>Wealth quintile</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>20.1</td>
<td>26.4</td>
<td>71.0</td>
<td>32.2</td>
</tr>
<tr>
<td>Q2</td>
<td>29.4</td>
<td>40.3</td>
<td>77.9</td>
<td>43.0</td>
</tr>
<tr>
<td>Q3</td>
<td>54.1</td>
<td>60.4</td>
<td>91.4</td>
<td>59.1</td>
</tr>
<tr>
<td>Q4</td>
<td>67.2</td>
<td>73.2</td>
<td>96.1</td>
<td>74.4</td>
</tr>
<tr>
<td>Q5</td>
<td>87.0</td>
<td>84.0</td>
<td>94.7</td>
<td>78.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>50.9</td>
<td>56.9</td>
<td>85.9</td>
<td>57.0</td>
</tr>
</tbody>
</table>

Source: QUIBB 2011.
4.2.2 Supply-side bottlenecks: Infrastructure, human resources, and medicines

The PNDS prioritises primary health care but Government of Angola faces great challenges to achieve this in practice. Primary health care, including its promotional, preventive and curative dimensions, should be provided through lower level health facilities (health posts and health centres) and through outreach services. Health posts and centres make up the first level of a three-tier health system and are managed by the municípios. According to the PNDS, primary health care services should respond to 85 per cent of all demand for health care and help to make the health system more cost-effective and equitable. The PNDS accordingly states that “from 2012, the allocation of public resources will have to give absolute priority to the first level of services based on primary health care...” (MINSA 2012, volume 1, page 52).

The Plan paints a bleak picture of the current state of primary health care services:

“In general the network of primary level infrastructure has old facilities that are in a bad state of repair and poorly resourced in terms of equipment and personnel. Many facilities still lack basic conditions for functioning, such as water, energy, sanitation and other inputs. Of the 1,854 functioning health facilities, 22 per cent are of makeshift construction and 51 per cent do not have drinking water.” (PNDS, volume 1, page 61)

“Health posts are the most numerous type of health facility across the country, and constitute the main point of entry to the National Health Service. However, their widespread presence has a very limited impact on the improvement of the health of communities, both with respect to the number and competence of their professional staff and in terms of the limited supply and quality of the services that they provide, resulting in very low cost-effectiveness” (PNDS, volume 2, page 258)

Basic service delivery functions far below established norms. According to data cited in the PNDS, the National Health Service has a total 2,356 health facilities, of which more than one fifth (21 per cent) are not functioning and more than half (1,200) do not have a supply of electricity, limiting their opening hours as well as the use of equipment. Many facilities lack basic instruments, such as stethoscopes (available in only 40 per cent of health facilities) and weighing scales (available in 47 per cent of facilities). Only 67 per cent of all health facilities have cold chain equipment. As a result of these and other gaps including frequent drug stock-outs (see below), only half of all first-level health facilities provide a full package of primary health care services and 18 per cent offer family planning services. Basic emergency obstetric services are available in only 166 health facilities and comprehensive emergency obstetric services in just 51 facilities. Patients complain in particular about long waiting times, drug stock-outs and out-of-pocket costs (see Figure 4.5).

While many first-level health facilities are unable to provide a full set of basic services, the referral system is also weak and disorganized. Referrals operate haphazardly as Angola does not currently have a clear set of norms and procedures to guide referrals within the health system. In the less developed and more sparsely populated provinces, referral mechanisms are often ineffective without a more extensive network of second-tier health facilities and the provision of ambulances. A severe shortage of ambulances and other vehicles hinders access to the second-level facilities and crucial services provided there such emergency obstetric care.
There are large deficits in health infrastructure in both urban and rural areas albeit for different reasons. Remote rural populations are often far from any health facility. According to the QUIBB 2011, 71 per cent of the rural population lives more than 40 minutes from any health facility and only 11 per cent can reach a hospital within 40 minutes. In contrast, health service infrastructure in urban areas and particularly in Luanda is physically closer but is overwhelmed by the size of the population it must serve. Applying INE population estimates for 2012 to MINSA data on the distribution of health facilities, the average population per health facility is by far highest in Luanda at 46,809, followed by Bié with 12,039 (see Figure 4.7). A much larger network of health centres is needed to meet the needs of populations in urban and peri-urban areas of Luanda.

The National Health Service has a severe shortage of qualified personnel. According to WHO, Angola has only 0.08 physicians per 1,000 population, compared to 0.37 in Namibia and 0.34 in Botswana (WHO 2013). MINSA data and INE population estimates offer a more optimistic ratio of 0.18 physicians per 1,000 inhabitants, but this is still only half the number in neighbouring Namibia and Botswana. There is also a large shortfall in other health cadres including midwives (0.01 per 1,000 population), greatly undermining the provision of maternal health services.

Health personnel are heavily concentrated in the major cities, especially Luanda. Although the number of facilities per capita is lowest in Luanda, these facilities are relatively well staffed – no less than 42 per cent of physicians are in Luanda, far more than Luanda’s share of the national population (28 per cent). As Figure 4.6 shows, the population per physician is particularly high in some southern provinces, especially Huila (42,816) and Kuando Kubango (26,293). These figures are respectively seven and four times higher than in Luanda (6,014). Provincial-level data masks even greater disparity between urban and rural areas. Overall, 85 per cent of physicians are in Luanda and the provincial capitals. As the PNDS observes, “the main consequences of this asymmetrical distribution are inequity in the quality of services provided, the overloading of the general hospitals, delays in handling patients (long waiting periods for surgical operations) and, most of the time, an increase in mortality” (page 211 of volume 2).
A strong human resource strategy is required and major initiatives are underway to increase the number of qualified health personnel. Five new faculties of medicine have been set up in the provinces of Benguela, Cabinda, Huambo, Huila and Malange, and their first cohort of doctors graduated in 2014. Together, these faculties should be graduating approximately 1,000 physicians a year by 2020, drastically augmenting the total of 3,541 physicians practising in the National Health Service in 2011. In addition, a decree in 2012 set up 13 new schools for training mid-level technical health staff. To address rural-urban disparities, training investments need to be accompanied by incentives that attract and retain physicians and other health professionals in the smaller towns and rural areas, but no such incentive system is yet in place. Decrees in 2003 established hardship subsidies for medical personnel working in remote areas; however these subsidies were never implemented. Subsequent deconcentration of management responsibility for health personnel to the provincial and municipal levels has made it more difficult for the national ministry to plan and implement measures to improve equity in the territorial distribution of human resources (MINSA 2012).

Procurement and distribution systems for medicines currently fail to ensure that health facilities have adequate stocks. The PNDS states that “constant stock-outs lead to the worsening of the population’s state of health” (volume 2, page 266). Following the adoption of a National Pharmaceutical Policy in 2010, in 2011 the Government set up a new agency for centralized drug procurement and distribution, the Central de Compras e Aprovisionamento de Medicamentos (CECOMA). Improved drug management will require the use of transparent, competitive public procurement mechanisms, the establishment of a nationwide computerized management information system and procedures for planning and prioritizing procurement (including the adoption of a national list of essential medicines), investments in improved logistics (warehouses, refrigeration and transport), the training of personnel and increased funding. Strengthened capacity for pharmaceutical inspection and a dedicated national laboratory for quality control are also urgently needed. A strategic plan for the pharmaceutical sector is envisaged.

The health system needs to engage in active outreach to communities to extend the coverage of promotional, preventive and curative services. The norms for implementation of the essential package of maternal and child health care services, prepared by the Ministry of Health with the support of UN agencies in 2007, outlined a proactive system whereby mobile teams are used to deliver health

---

**Figure 4.6 Population per health facility and per physician by province, Angola, 2012**

![Population per health facility and per physician by province](image)

Source: PNDS (MINSA 2012) and INE population estimates for 2012. Calculated from 2012 population estimates and latest available data on infrastructure and personnel.
under-five care services in remote communities. However, apart from nationally organized preventive campaigns for immunization, vitamin A supplementation, deworming and distribution of bed-nets, outreach has been weak. Few municipal health services have been able to organize and implement regular outreach to rural communities due to lack of transport, drug shortages and human resource constraints.

A strong system of community-based health promotion, prevention and basic curative care would complement and relieve pressure on facility-based services, but is weakly implemented in Angola. Community-based health care has yielded positive benefits in many developing countries
58 and was an integral part of the Angolan health system in the immediate post-independence period but collapsed when the war escalated in the 1990s. The National Health Policy adopted in 2010 and the PNDS envisage the reestablishment of a system of community-based promotional, preventive and simple curative services through community health workers or agentes comunitários de saúde (ACS), linked to and supported by health facilities. Pilot schemes deploying ACS were recently sponsored by the Ministry of Health and selected provincial governments with the support of UNICEF and other development partners. The Ministry of the Family and Promotion of Women (Ministério da Família e Promoção da Mulher or MINFAMU) has provided similar support to traditional birth attendants (TBAs) in some provinces. However, community-based initiatives have been funded mainly by donors on an ad hoc basis and have not yet been adopted within any national programme59.

The PNDS provides a powerful framework for strengthening the health system, but effective implementation requires a much stronger information system. The existing Health Information System does not function properly. The lack of robust service data poses great challenges for planning and implementation and rebuilding this system is critical for rational management of the health system.

Implementation of the PNDS will also require a large increase in health sector funding, which has received a declining share of the budget in recent years. In 2011, the health sector received 6.8 per cent of budgeted government expenditure (excluding debt service) and just 5 per cent in 2014.60 The allocation for health, which includes military as well as civilian health services, is just one third of the target of 15 per cent set by African governments in the AU’s Declaration of Abuja in 2001 and approximately three quarters (77 per cent) of the required expenditure of Kz409 billion projected in the 2014 PNDS budget61 (MINSA & USAID 2013). Despite the prioritisation of primary health care declared in the PNDS, health spending appears to be heavily skewed towards secondary and tertiary care, with a large portion of the 2014 health budget allocated to general and specialized hospital services. More in-depth analysis of health expenditure is difficult however, as recent health expenditure data are not publicly available and even the PNDS budget lacks a baseline.

4.2.3 Health behaviours and demand-side barriers to use of health services

Access to health care depends not only on the supply and quality of health services but also on demand. The IBEP 2008-2009 found that among children under five who had fallen ill in the previous month, only 58.7 per cent were taken to a health provider and this proportion was much lower in rural areas. The main reasons parents gave for not taking their children to health facilities when they were ill were that the child was not sick enough to need a health consultation (36 per cent), high cost (21 per cent), distance (20 per cent) and lack of a health facility (16 percent) (see Figure 4.7).
Figure 4.7 Main reasons given by parents for not taking children under 5 to health facilities when they were ill (during the 30 days preceding the survey)


Although the National Health Service is supposed to provide health care free of charge, the cumulative costs of seeking care – including both the direct (fees) and indirect costs such as transport or opportunity costs – remain a barrier for many families. National health accounts produced with WHO support in 2008 showed that the Government of Angola finances approximately two thirds of total health expenditure (65 per cent), while the remaining third is financed primarily through individual spending (23 per cent), followed by public and private companies (9 per cent) and international partners (3 percent) (MINSA 2012). These figures include expenditure by wealthier Angolans on private health services. For those attending government health facilities, the cost of medicines can be a major expense. Drugs are officially provided free of charge in the National Health Service, but as noted earlier, frequent stock-outs force patients to purchase medicines at private pharmacies or in the unregulated informal market (see Section 4.2.2). Patients also sometimes incur informal costs at the point of service to facilitate or speed access to services. Improvements to the quality of public health care provision and in particular to the supply and distribution of medicines would help to alleviate some of the cost-related barriers to health care.

Individual and community practices related to health including health-seeking, are strongly linked to education. Ample evidence is available showing a correlation between the educational level of mothers and/or household heads and health outcomes for children in Angola. See for example data in Figures 4.2 and 4.3, linking education to malaria treatment and prevention and in Table 4.1, to the use of maternal health services. Because educational levels are closely related to urban-rural residence and household wealth – important determinants of health – multivariate regression analysis would be needed to measure the relative importance of education as a causal factor of health practices and outcomes. Nonetheless, it is likely that low levels of education and implicitly poor rates of adult literacy have a direct effect on some health outcomes by limiting access to knowledge.

There are major gaps in health-related knowledge, attitudes and practices (KAP) with significant consequences for nutrition, hygiene and HIV/AIDS. Knowledge, beliefs, and cultural norms contribute to low rates of exclusive breastfeeding of children under six months, low levels of hand-washing and treatment of water for drinking, open defecation in rural areas, and increased HIV risk, particularly among women and in rural areas. Low levels of knowledge about malaria transmission might also contribute to its spread; for example, the 2011 MIS found that 27 per cent of women aged 15-49 do not know that malaria is transmitted by mosquito bites and that 30 per cent do not know that it can be avoided by sleeping under a bed-net. The proportions of women without basic knowledge about malaria transmission and prevention are much higher in rural areas: 41 per cent and 45 per cent respectively, explaining in part why even in households that own a bed-net, less than two thirds of children under 5 (61 per cent) actually sleep under one (see Figure 4.8).
Figure 4.8 Knowledge and practices related to malaria prevention in urban and rural areas of Angola, 2011

Source: MIS 2011.

Underlying socio-cultural norms, attitudes and practices related to reproductive and sexual health, heighten the risks of maternal and child mortality as well as HIV transmission (see Section 4.5). These practices include early initiation of sexual intercourse and low rates of contraceptive use resulting in early pregnancy (before reaching physical and/or social maturity) and high fertility. Childbearing commonly starts very young: the IBEP 2008-2009 found that 55 per cent of females aged 15-19 gave birth before the age of 20, and that 7 per cent gave birth for the first time before they were 15 (see Figure 4.9). Young women who give birth before they have reached physical maturity are more likely to have complications during childbirth and evidence from many countries shows that their newborn babies have a higher risk of low birth weight, increasing the risks of both maternal and neonatal death. Although data are not available on birth spacing for Angola, given the high total fertility rate (6.3 children per woman rising to 7.7 in rural areas), it is likely that inadequate spacing poses additional risk to mothers and newborns (see Chapter 2). Barely 12 per cent of women aged 12-49 in marital union use modern contraceptives (IBEP 2008-2009).

Figure 4.9 Percentage of women aged 12-19 who have given birth at least once by age group and residence


Data from the Mozambique Demographic and Health Survey in 2011 shows that the risk of dying before the age of 5 is 2.1 times higher for children born to mothers less than 18 years old and 2.3 times higher for children born less than 24 months after a previous birth, compared with other children. When early pregnancy and a short birth interval (less than 24 months) are combined, the risk of death before the age of 5 is 4.35 times higher.
4.3 Child Malnutrition

Under-nutrition among children in Angola contributes significantly to child mortality and can cause permanent impairment to the cognitive development of young children compromising their well-being and productivity as adults. At a population-level, losses in human capital due to child under-nutrition can undermine economic growth and poverty reduction efforts. There is a dearth of data on nutrition in Angola, making analysis approximate at best, but the information that is available suggests that nutrition should be prioritized and interventions to reduce under-nutrition in children must be urgently expanded. The Government of Angola developed a National Nutrition Strategy for Young Children in 2011 (MINSA 2011b), and its main points, including a comprehensive package of measures to reduce under-nutrition, have been incorporated into the PNDS. As in other sectors, the Government must now translate strategy into practice.

4.3.1 Under-nutrition and micronutrient deficiencies

Almost one third of children aged 6-59 months suffer from stunting, according to the National Nutrition Survey (NNS) conducted in 2007. Although it is now seven years out of date, the NNS is the most recent available source of nationally representative survey data on under-nutrition in Angola (MINSA 2007). The NNS found that over 16 per cent of children aged 6-59 months were underweight (weight for age) and estimated the prevalence of stunting in children under 5 – a result of chronic under-nutrition – was 29 per cent.

Chronic under-nutrition is caused by a protracted deficit in the intake of nutrients and is an important indirect determinant of child mortality. Children who survive chronic under-nutrition can suffer irreversible damage to their health and development. Under-nutrition weakens children’s resistance to disease while illness contributes to under-nutrition, and this synergy between childhood illness and stunting is estimated to contribute directly or indirectly to 45 per cent of deaths in children under 5 worldwide (The Lancet 2013). Maternal under-nutrition during pregnancy and chronic under-nutrition during the first two years of life before the brain is almost fully formed (the first 1,000 days), can have long-term effects on growth and permanently impair cognitive development. Numerous studies have shown that chronic under-nutrition during the first 1,000 days of life can have serious negative effects years later on children’s learning achievement in school and their productivity and earnings as adults.

Chronic under-nutrition on the scale seen in Angola can have population-level impacts on human capital and is therefore a significant threat to national socio-economic development. While the available data does not allow specific estimates to be made for Angola, the World Bank (2006) has calculated that globally, productivity losses in adult life from chronic under-nutrition in early childhood account for a 2-3 per cent loss in GDP.

In most areas outside Luanda, stunting rates were close to or exceeded 30 per cent, the threshold set by the WHO for defining a health threat as having a “high level of public health significance” (see Figure 4.1). The prevalence of stunting among children under 5 years was 33 per cent in rural areas and 30 per cent in ‘other urban areas’, but much lower in Luanda (19.6 per cent). The geographic regions with the highest prevalence of stunting were the West (Benguela and Kwanza Sul), the South (Cunene, Huila and Namibe) and the Central South (Bié, Huambo and Kuando Kubango), with rates of 34.3 per cent, 33.7 per cent and 31.3 per cent respectively. With the East (Lunda Norte, Lunda Sul and Moçíaco), these regions also had the highest proportions of underweight children.63

63 Unfortunately the NNS 2007 did not construct wealth quintiles and so it was not possible to analyse disparities in socioeconomic terms.
It is not possible to calculate trends accurately due to a lack of data, but there appear to have been major improvements in the nutritional status of children since the end of the conflict. Two national surveys collecting data on nutrition (MICS 1 in 1996 and MICS 2 in 2001) were conducted before the NNS in 2007, however neither of these surveys is considered to be nationally representative because of limited access into conflict-affected areas. Nonetheless, applying the new Child Growth Standards adopted by WHO in 2006 to anthropometric data from the 2001 MICS allows for some consistency with measurements used by the NNS and suggests that stunting declined between 2001 and 2007. In 2001, 51 per cent of children were stunted – among the highest rates in the world. By 2007, stunting among children under 5 had declined to 29 per cent – an improved though still worrying rate. As the conflict-affected areas unreached by the MICS in 2001 were likely to have worse nutritional outcomes than accessible areas, the real national stunting rate at that time may have been even higher than 51 per cent.

Although no recent data is available, it is likely that acute malnutrition (wasting) increased during the last three years due to a drought emergency in 2012 that affected much of the country and in particular the southern provinces. In 2013, the NGO World Vision reported that global acute malnutrition reached 24 per cent among children screened in drought-affected municipios in Cunene and 29 per cent in Huila (UN 2013). Wasting, or low weight for height, reflects a short-term lack of nutrients, usually associated with reduced food intake. Wasting typically increases in rural areas during the ‘hungry season’ before harvests, as a result of drought, or with persistent or recurring illness. It is a life-threatening condition requiring immediate supplementary feeding or therapeutic feeding in severe cases. The NNS 2007 reported that more than eight per cent of children under 5 suffered from acute malnutrition (wasting). This rate was virtually unchanged from 2001 estimates, although caution must be exercised in interpreting trends. Surprisingly, the NNS found higher acute malnutrition rates in the capital (10 per cent) than in rural areas (8 per cent) and other urban areas (7 per cent), for reasons that are not immediately obvious.

64 Data are from the WHO Global Database on Child Growth and Malnutrition.
65 Global Acute Malnutrition (GAM) is the sum of the prevalence of severe acute malnutrition (SAM) plus moderate acute malnutrition (MAM) at a population level. MAM is defined by WHO/UNICEF as: Weight-for-Height Z-score < -2 but > -3. SAM is defined as Weight-for-Height Z-score < -3 or a mid-upper arm circumference of <11.5 cm or the presence of bilateral pitting oedema or visible wasting.
In addition to under-nutrition, micronutrient deficiencies also threaten the growth, development and survival of infants and young children in Angola. Micronutrients are the vitamins and minerals essential for healthy growth and development. As elsewhere in the developing world, the most common micronutrient deficiencies in Angola are of vitamin A, iron, iodine and zinc. These deficiencies have serious consequences, particularly for children. Iron is crucial for the motor and cognitive development of young children, and is also important for women during pregnancy to meet the needs of the growing foetus. Iron deficiency (anaemia) heightens the risk of preterm birth, low birth weight and maternal mortality due to haemorrhage. Vitamin A plays a crucial role in the immune system and Vitamin A deficiency (VAD) contributes substantially to child mortality. Zinc is similarly important to the immune system while iodine is crucial for development of the brain. Iodine deficiency is the leading cause of preventable mental retardation worldwide and the World Bank has estimated that chronic iodine deficiency reduces average IQ by 13.5 points (World Bank 2006). Although the evidence-base is limited, micronutrient deficiencies appear to be widespread in Angola (See Box 4.2).

**Box 4.2 Micronutrient deficiencies in Angola**

**Iron deficiency (anaemia)**
According to the WHO Global Database on Anaemia, anaemia (defined as a haemoglobin level of less than 110 g/L) affects almost 30 per cent of preschool-aged children and 57 per cent of pregnant women in Angola (WHO 2009a). However, the figures are drawn from a survey conducted more than a decade and a half ago, in 1998/99, when Angola was at war and there was limited or no access to populations in many parts of the country. There are more recent data for the prevalence of severe anaemia within a slightly narrower case definition (haemoglobin < 80g/L), from the Malaria Indicator Surveys (MIS) in 2006/07 and 2011. These data show a decline in severe anaemia prevalence among children aged 6-59 months from 3.6 per cent in 2006/07 to 2.6 per cent in 2011. Prevalence is highest in the 6-11 months age group (5.2 per cent), suggesting that adequate iron-rich foods are not being introduced into children’s diets after weaning. As would be expected, there is a strong correlation between the prevalence of severe anaemia and household wealth, with rates declining from 4.5 per cent and 4.2 per cent in the poorest two quintiles to 1.7 per cent in the richest quintile. The data also show higher prevalence of anaemia in the hyper-endemic malarial areas. Strangely, both the 2006/07 and 2011 MIS show that severe anaemia is more prevalent in urban than rural areas while it is lowest in Luanda (1.6 per cent).

**Iodine deficiency**
Although no data are available on the prevalence of iodine deficiency itself, both the MICS in 2001 and the NNS in 2007 provide data on the proportion of households consuming adequately iodized salt (> 15 parts per million) – the main source of iodine. Although older data need to be interpreted with caution for reasons already discussed, the two available sources show an improvement in the prevalence of iodine consumption from 35 per cent in 2001 to 45 per cent in 2007. However, more than half of households still do not have an adequate source of iodine. The NNS found stark regional differences in iodized salt consumption with extremely low levels in the North (17 per cent) and North East (20 per cent) (see Figure 4.11). This has been attributed to the smuggling of non-iodized salt from the Democratic Republic of Congo (McDonald et al, 2011). Unfortunately no more recent data are available.

**Vitamin A deficiency (VAD)**
The only data available for VAD come from the WHO Global Database and are very outdated (the estimates are drawn from the same 1998-1999 survey as the anaemia data). At this time, VAD prevalence was 64.3 per cent in preschool-aged children and 15 per cent among pregnant women. (WHO 2009b)

**Zinc deficiency**
No national data are available for zinc deficiency, but in 2009 the Micronutrient Initiative estimated that 46 per cent of the Angolan population may not consume adequate amounts of zinc.

---

66 The 2007 NNS did not collect the necessary biochemical data to make estimations of the prevalence of micronutrient deficiencies.
Nutritional problems in Angola have multiple causes including food intake, disease and access to health services, and care and hygiene practices. Many Angolan households simply do not have adequate access to food as a result of poverty and food insecurity. The number of meals that households consume per day is a useful proxy indicator for measuring access to adequate food. The 2011 QUIBB survey found that nationally, 9 per cent of households have only one meal a day. In the poorest wealth quintile, only 18 per cent of households have three or more meals a day compared with 62 per cent in the richest quintile (see Figure 4.12). A nutritionally diverse diet is particularly important for children and pregnant women. Less information is available on dietary diversity in Angola, however it was estimated that half of households consumed meat at least once a week, while 75 per cent consumed fish and 92 percent had green vegetables at least once a week. Households in the poorest quintile consume far less meat (50 per cent) and fish (31 per cent) per week than wealthier households. Childhood diseases such as malaria, diarrhoea and ARI contribute to poor nutritional outcomes, while nutritional deficiencies and in particular micronutrient deficiencies, reduce children’s resistance to disease, creating a vicious circle of cause and effect. Childcare, feeding and hygiene practices, as well as environmental risks and lack of access to improved water sources and sanitation, further contribute to poor health and nutrition outcomes, especially in rural areas (see Section 4.5).
Poor infant and young child feeding practices are widespread in Angola. To ensure the adequate growth, development and survival of infants and young children under the age of two, WHO recommends that breastfeeding is initiated within one hour of birth, that infants are exclusively breastfed for the first six months of life, that they receive age-appropriate nutrient-dense foods from six months of age, and that they continue to be breastfed beyond at least 12 months of age. There are serious shortfalls for all these practices in Angola. While 90 per cent of infants are breastfed at some time, only 55 per cent initiate breastfeeding immediately after birth (NNS 2007). Less than one third (31 per cent) of children under 6 months of age are exclusively breastfed, with large geographical variation ranging from 11 per cent in the eastern Angola to 43 per cent in the west (see Figure 4.13). Feeding practices might reflect regional differences in cultural beliefs and/or knowledge about the benefits of breastfeeding and the risks associated with early introduction of other liquids or solids.

Figure 4.13 Proportion of children under 6 months exclusively breastfed by region (%), Angola, 2007

![Proportion of children under 6 months exclusively breastfed by region](source: NNS 2007)

4.3.2 Scaling up an integrated package of nutrition interventions

At a policy level, commitments have been made to scale up a comprehensive set of nutrition interventions however, implementation is slow to follow. The National Food Security and Nutrition Strategy (Estratégia Nacional de Segurança Alimentar e Nutricional or ENSAN) was adopted in 2009 and endorsement by the Minister of Health of a more specific strategy for the nutrition of infants and young children followed two years later (MINSA 2011a). Implementation of ENSAN is coordinated by the Ministry of Agriculture and Rural Development (Ministério da Agricultura, Desenvolvimento Rural or MINAGRI) but overseen by a broader multi-sector body, the National Council for Food Security and Nutrition, directly linked to the Presidency. It focuses in particular on improving food production and strengthening domestic food markets, while also improving access to food by vulnerable groups through social protection mechanisms – a major national priority that has not yet been fully implemented (see Chapter 7). Within the Ministry of Health, a dedicated section for nutrition is responsible for coordinating implementation of the strategy for nutrition of infants and young children. One of the main objectives of this strategy is to reduce the prevalence of chronic under-nutrition in children under-5 to less than 10 per cent by 2015. It is noteworthy that the health components of nutrition strategies have also been incorporated into the PNDS 2012-2021 (MINSA 2012). In addition, the second of the 11 Commitments for Children is devoted to food and nutritional security for children aged up to 5 years (CNC 2011). However, much needs to be done to translate these commitments into programmes and front-line interventions.
The national nutrition strategy for infants and young children – cited in both the ENSAN and PNDS – sets out a package of 11 priority interventions to address the health and behavioural dimensions of child nutrition. The most crucial of these priority interventions are:

- Measures to tackle the vicious cycle of malnutrition and infection;
- Behaviour change interventions, including for the promotion of exclusive breastfeeding in children under 6 months and the introduction of appropriate complementary feeding after 6 months;
- Measures to reduce micronutrient deficiencies, including micronutrient supplementation, fortification of locally-produced foods, and promotion of healthy dietary practices;
- Treatment of acute malnutrition, including through increased access to community management of malnutrition and better implementation of protocols for treatment of acute malnutrition.

The Government’s official package of measures for improving the nutrition of infants and young children is broadly consistent with global best practice. The package is in line with interventions recommended in a recent global review of evidence on child nutrition published by the medical journal The Lancet (2013). There is broad international consensus around the recommended package of interventions for child nutrition; however, some globally recommended interventions have not been included in Angola’s strategy including the use of zinc supplementation for the treatment of diarrhoea, micronutrient powders for young children, vitamin A supplementation for postpartum women and iron fortification of staple foods.

Angola now faces the challenge of translating strategic intentions into action and to scale up effective interventions to achieve full national coverage. Due to the lack of reliable, consolidated administrative data on nutrition programmes, it is difficult to assess the extent to which the officially endorsed package of interventions is currently being implemented. Anecdotally, it is known that while some interventions are being rolled out, the scope and scale of implementation still falls short of needs. The limited information available on current nutrition programming is presented below:

(i) Behaviour change interventions
A small number of awareness campaigns have been launched to promote behaviour change, but there is little information on their coverage or results. The Baby Friendly Hospital Initiative provided counselling to mothers on breastfeeding until financing from UNICEF ended in 2012. However, facility-based education cannot reach women who do not deliver in health facilities – currently more than half of all mothers in Angola. UNICEF has also supported a ‘family competencies’ programme which uses community activists to promote good practices in infant and young child feeding, hygiene, and other behaviours important to child health and nutrition. Currently there is virtually no use of mass media (radio or television) to promote good breastfeeding practices.

(ii) Preventing micronutrient deficiencies
Progress in the fight against micronutrient deficiencies presents a mixed picture. Vitamin A supplementation provided once a year to children aged 6-59 months, reached a national coverage rate of 84 per cent in 2013 (Ministry of Health). The only available survey data dates to 2007 and showed that at that time, 68 per cent of children aged 6-59 months had received vitamin A supplements in the previous 6 months (NNS 2007). The gains in coverage are encouraging; however, annual vitamin A supplementation still falls short of the medical recommendation of twice-yearly supplementation for prevention of VAD. Although the PNDS envisions the fortification of staple foods with iron, this is not yet standard practice. Nor are measures in place to provide iron and folic acid supplements to women except to pregnant women.
as part of antenatal care, and those who don’t attend ANC visits do not have access to supplements (see Section 4.2.1). Iodine deficiency was addressed in 2008 legislation requiring all salt to be iodized (Decree-law No 79/08) and as far back as 1997, the Government set up a National Iodine Technical Commission with a secretariat in MINADERP, to oversee implementation of earlier government regulations. However it has proven problematic to ensure effective compliance with the law, which was not complemented with any decree setting out detailed implementation procedures. In 2012, UNICEF noted a number of constraints to addressing iodine deficiency, including the lack of subsidies or financial incentives such as import duty or VAT waivers for iodized salt and the lack of a strong monitoring and enforcement system. Potassium iodate, which is used to iodate salt, is provided free but sporadically to producers (either by the Government or UNICEF). There seems to have been considerable progress in ensuring that most salt produced in Angola is iodized (estimated 89 per cent in 2011), however national production covers just one quarter of national needs and less than half of the salt used for human consumption. While most of the salt imported through the main ports is iodized, this is not the case for cheaper salt smuggled into the country across its porous land borders, especially from the DRC.

(iii) Prevention and treatment of acute malnutrition

The drought emergency in 2012 and 2013 drove a major expansion of services in for treatment of acute malnutrition in affected areas, but still only a minority of affected children were reached and efforts to prevent acute malnutrition remain inadequate. In 2013, in response to the drought, the Government rolled out a national contingency plan in six provinces (Cunene, Kwanza, Huila, Namibe, Benguela and Kwanza Sul). The number of functional in-patient facilities (IPF) for the treatment of severe acute malnutrition increased from just 24 in nine provinces in June 2012 to 61 in eleven provinces by June 2013. In addition, 38 per cent of the health centres and health posts (606 out of 1,590) in affected provinces had functional outpatient therapeutic programmes (OTP). In 2013, IPF and OTP services treated approximately 44,400 children with severe acute malnutrition (SAM). The Ministry of Health also launched promotion of community management of acute malnutrition (CMAM), which is proven internationally to be a highly cost-effective strategy69 and for which guidelines were issued in Angola in 2011. Given the dispersed nature of rural populations and the limited coverage of health facilities in rural areas, CMAM is particularly appropriate in Angola, however is still not widely implemented. In 2013, CMAM was operational in only 22 of the country’s 164 municípios financed through UN emergency funding. That year community health workers provided treatment to 29,400 children with SAM and just over 65,000 children with moderate acute malnutrition (MAM). Based on estimates from a rapid nutrition assessment conducted in April and May 2013, global acute malnutrition related to the drought affected over 533,000 children. It can therefore be estimated that treatment programmes reached approximately 26 per cent of children in need. In spite of the expansion of services, three quarters of affected children were not reached, and those who were, accessed treatment through the support of NGOs with donor funding that will be difficult to sustain in future.

Institutional capacity and human resources for nutrition are currently insufficient to deliver comprehensive nutrition programming at a national scale. There is a critical shortage of qualified nutritionists at all levels, and urgent action is needed to train enough nutritionists to work in the municípios, which at present do not have any staff with specific qualifications or mandate for nutrition. The emergency response to drought-related surges in acute malnutrition provided rapid training for community health workers. However, to meaningfully strengthen nutrition services and translate existing strategies into costed operational plans, timely and reliable information is necessary. A standardized nutrition surveillance system is needed along with stronger monitoring and evaluation mechanisms to identify needs, gaps and bottlenecks and guide scale-up and budgeting.

69 See evidence from Zambia (Bachmann, 2009) and Bangladesh (2010).
The interventions set out in the national nutrition strategy for infants and young children are relatively inexpensive and have high social and economic returns. Global evidence shows that by ensuring adequate nutrition during the critical 1,000-day window from pregnancy to age two, irreversible and long-term damage to children’s health and cognitive and physical development can be prevented (The Lancet 2013). Furthermore, several studies have shown that these interventions can be implemented at a low cost and that they bring huge returns in the form of lives saved and longer-term economic benefits (Horton et al 2010). The benefits of these interventions may stretch far into the future as the health and wellbeing of today’s infants and young children will feed the creativity, productivity and prosperity of the next generation of adults in Angola.

4.4 Children and HIV/AIDS

Angola has so far been spared from the human and economic ravages that HIV/AIDS has brought to other Southern African countries, however bottlenecks in service delivery and weaknesses in the health system leave no room for complacency. Adult HIV prevalence in Angola is currently estimated at 2.3 per cent and has been stable during past few years (UNAIDS 2013). However, the coverage of prevention, treatment and care interventions is low and has even worsened in the last few years, particularly in the area of paediatric AIDS and the prevention of mother to child transmission (PMTCT). The Government recently launched an accelerated response plan to address these challenges. Angola is one of the 22 high priority countries targeted by the Global Plan towards the Elimination of New HIV Infections among Children and Keeping their Mothers Alive, adopted by the United Nations General Assembly High Level Meeting on AIDS in July 2011.

4.4.1 Profile of the epidemic

Every year an estimated 28,000 people including 5,100 young children are newly infected with HIV and about 13,000 people – 2,600 under 15 years old – die from AIDS.

HIV prevalence is higher among women than men. Women are physiologically more vulnerable to infection and generally have higher risk due to low condom use, polygamy, and strong social norms that restrict women’s autonomy in relationships. Higher levels of illiteracy and lower access to information among women limit their ability to prevent and seek treatment for HIV and AIDS (see below). The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that women account for about 59 per cent of the infected population aged 15 and over in Angola.70

Angola is the only one of the 22 Global Plan priority countries in which the number of new HIV infections among children has continued to increase. From 2009 to 2012, new HIV infections among children increased a cumulative 9 per cent. Young children are generally infected through their mothers, who can pass on the virus either in the uterus, during childbirth or through breastfeeding. According to models of HIV/AIDS data, approximately 20,000 pregnant women living with HIV deliver each year. In 2013, an estimated 29,000 children under 15 years were living with HIV, up from 23,008 in 2010 (UNAIDS 2013 and INLS 2012).

4.4.2 The national response to HIV/AIDS: prevention, treatment and care

Eight out of ten pregnant women living with HIV in Angola do not receive antiretroviral medicines to prevent mother to child transmission (PMTCT). Antiretroviral therapy (ART) for PMTCT can reduce the risk of transmission to less than 2 per cent. However, coverage of the PMTCT programme, which began in 2004, is low and inconsistent. The rate of HIV transmission from infected mothers to their children has therefore not improved in recent years, remaining at around 33 per cent between 2009 and 2012 (UNAIDS 2013).

70 Derived from models using data from HIV testing during ante-natal care consultations.
Increasing PMTCT coverage is an urgent priority. In 2007, the integration of PMTCT services into mainstream reproductive health services combined with the expansion of testing facilities across the country, initially made it possible to expand coverage of pregnant women living with HIV from 14 per cent in 2008, to 16 per cent in 2009 and 31 per cent in 2010 (INLS). However, the INLS reported that PMTCT coverage declined in 2011, falling to 23.5 per cent (INLS 2012). Further, these figures appear to account only for those women with HIV who used antenatal care services. If PMTCT coverage is estimated for the total number of pregnant women living with HIV, the proportions are even lower: 39 per cent in 2013 (UNAIDS 2014). Poor PMTCT coverage rates are linked to inadequate testing of pregnant women, low coverage of those detected with the HIV virus (falling from 63 per cent in 2010 to 54 per cent in 2011) and low adherence to treatment among those who are initiated on a regimen for PMTCT. Adherence ranges from 55 per cent to 65 per cent in the majority of provinces (INLS 2012).

While ART coverage has increased since 2008, it remains low, especially among children. According to official estimates, ART coverage of the eligible population has increased from 19 per cent in 2008 to 36 per cent in 2011 (INLS 2012). Despite this improvement, the majority of those in need of treatment do not receive it. Children are particularly disadvantaged: only 15 per cent of eligible children under age 15 receive treatment as compared with 48 per cent of those over 15 (see Figure 4.14). Furthermore, until 2013 there was only one paediatric ART regimen available in the country, limiting the options to adjust or adapt treatment to meet the different needs of very young children and avoid harmful side effects.

Gaps in ART coverage reflect low rates of HIV testing. Although there has been an impressive increase in the number of facilities providing HIV testing, from just eight in 2003 to 811 in 2011, overall only a small proportion of the target population gets tested. Pregnant women, as the easiest group to reach through antenatal care services, accounted for 55 per cent of all those tested in 2010 and 2011. However, even coverage of pregnant women is limited because not all women attend antenatal consultations (see Section 4.2.1), and also because testing services are available in only two thirds of municípios (111 out of 164 in 2011). HIV testing is further hampered by frequent stock-outs of rapid test kits. The 2010 INCAPSIDA survey found that overall only 15.4 per cent of women and 14.9 per cent of men aged 15-49 had been tested in the previous year and knew the result of their test. Testing coverage was even lower among younger women: only 7.8 per cent of those aged 15-19 and 11.1 per cent of those aged 20-24 had been tested in the previous year and knew the result.

HIV testing of infants born to HIV positive mothers is historically low. HIV testing in infants is more difficult than in older children or adults because rapid tests cannot be used and the country’s only molecular biology laboratory with capacity for DNA Polymerase Chain Reaction (PCR) is in Luanda and does not perform this procedure for early infant diagnosis. INLS estimates that PCR testing coverage of infants (<2 months old) born to HIV infected mothers was 7.6 per cent in 2011 (INLS, 2012). Following up on the recommendations of a Clinton Foundation project, which previously performed PCR for infants in Luanda, a new project to pilot PCR for early infant diagnosis is due to be launched in Luanda in 2014 and subsequently expanded to the provinces.

Knowledge and practices are still not conducive to protection against infection, especially among women and in rural areas. Most men and women in urban areas have heard of AIDS (95 per cent and 92 per cent respectively), but awareness of AIDS falls in rural areas to 72 per cent among men and 58 per cent among women (see Figure 4.15) [INCAPSIDA 2010]. Only 38 per cent of women aged 15-49 can correctly identify at least two ways of reducing the risk of HIV transmission: 44 per cent identified use of condoms or limiting sexual relations to a single partner and 37 per cent identified abstinence as means to avoid infection. Among youth aged 15-24, less than half of both men and women have ‘comprehensive’ knowledge of HIV/AIDS, defined as being able to (a) identify at least two ways of reducing the risk of HIV transmission, (b) reject common misconceptions about transmission, and (c) knowing that a healthy looking person can have HIV. Only 41.9 per cent of young women had comprehensive knowledge of HIV compared with 48.2 per cent of young men. Knowledge of HIV/AIDS has improved slightly since 2008 but remains unacceptably low.

Prevention of HIV transmission is undermined by low utilization of condoms. The 2010 INCAPSIDA found that only 19.8 per cent of women and 43.2 per cent of men who had more than one sexual partner in the previous year reported using a condom during their last sexual encounter. Rates of condom use are generally low in Angola: just 7.6 per cent of women in marital union aged 12-49 reported using condoms with their partners (IBEP 2008-2009).

Figure 4.15 Knowledge and practices related to HIV/AIDS (%)

![Figure 4.15 Knowledge and practices related to HIV/AIDS](image)


---

72 Knowledge of HIV prevention was slightly but consistently higher among men: 51 per cent of men knew of two prevention methods, 57 per cent identified condom use, 59 per cent identified limiting the number of sexual partners, and 51 per cent identified abstinence as ways to prevent HIV transmission.

73 Common misconceptions about HIV transmission included that HIV can be transmitted by mosquito bites or supernatural powers or by sharing food with an infected person.

74 IBEP 2008-2009 measured comprehensive knowledge of HIV transmission to be 25.3 per cent among young women and 32.1 per cent among young men.
Very few families and children affected by HIV and AIDS receive support to cope with the economic and psychosocial impacts of the disease. These impacts can be immense, often including loss of earnings from productive adults and the risk of a descent into poverty, social stigmatization, and serious psychosocial consequences – particularly for children – from the illness and loss of family members. It is estimated that 120,000 children in Angola have lost one or both of their parents to AIDS, yet there are virtually no programmes to support these children or their families.

New treatment guidelines adopted by the WHO in 2013 simplify treatment protocols and greatly expand access to treatment by recommending earlier initiation of ART and universal coverage of pregnant women and children with HIV. It is projected that if these guidelines are fully implemented, globally more than 19 million new cases of HIV and 12 million AIDS-related deaths would be averted by 2025 (WHO 2013). These guidelines raise the CD4 threshold for ART eligibility (so that more people access treatment earlier) and recommend that all pregnant women with HIV initiate antiretroviral prophylaxis regardless of whether they meet ART eligibility criteria.

It is crucial that Angola strengthens a multi-faceted response to HIV and AIDS to address gaps in awareness, testing, PMTCT, treatment and protection and care. Angola can still avoid the huge human, economic and fiscal costs that the HIV/AIDS pandemic has imposed on its SADC neighbours. To do so will require that Angola redouble efforts across the continuum of prevention, treatment, protection and care to reverse recent declines in the quality and reach of services and scale up coverage rapidly.

As in other areas of health care, political commitment to address HIV/AIDS is in place, but has not been followed by rapid and effective implementation. The Government adopted an accelerated response strategy which aims to eliminate new infections among young children by the end of 2015 by ensuring that 90 per cent of pregnant women infected with HIV receive ART, and that all adults, adolescents and children living with HIV who need treatment receive it. To reach this goal in 2015, ART coverage would need to have doubled and PMTCT coverage should have more than quadrupled since 2012. Based on trends in ART and PMTCT coverage between 2010 and 2012, it is very unlikely that Angola will meet these goals by 2015.

To achieve universal coverage of ART and PMTCT, it is first necessary to address general weaknesses in the health system and specific bottlenecks affecting service delivery. Health workers currently have limited capacity to provide PMTCT and paediatric AIDS services, particularly in rural areas. Capacity gaps are compounded by weak supervision and management. Trained health workers providing antenatal services are often overwhelmed by their workload and competing priorities. Weak integration of PMTCT services in antenatal clinics results in late diagnosis of HIV status among pregnant women and consequently late initiation of ART. Many women are only tested and diagnosed with HIV in the labour ward when it is too late. Once women are put on a PMTCT regimen, strategies are needed to improve poor adherence to treatment. Expanding PMTCT coverage also means addressing the wider issue of low utilization of antenatal and delivery services at health facilities.

Rapid investments are needed in capacity building, expansion of testing services to more municípios, mass testing and treatment campaigns (‘busca activa’) and the improvement of drug and testing kit procurement and distribution to avoid stock-outs. Paediatric AIDS services require special attention to increase the coverage of testing and treatment in young children. Improved knowledge and awareness of HIV is crucial to improve preventive behaviours and strengthen the demand for testing and treatment services. Awareness raising activities should specifically target women in rural areas. Finally, support for families affected by HIV and AIDS needs to be mainstreamed into stronger core social protection programmes, as will be discussed in Chapter 7.
4.5 Water, sanitation and hygiene

Lack of access to safe water and sanitation and poor hygiene practices are leading causes of infectious disease, contribute to under-nutrition and are a key driver of child mortality. In Angola, although coverage is expanding and already quite high in urban areas, access to improved water sources and sanitation facilities remains limited in rural areas. Many rural households still use high-risk surface water sources, such as rivers, ponds and lakes, and practice open defecation in the bush, aiding the spread of waterborne diseases. Few households treat their water, and hand washing is not widely practiced. Environmental conditions paired with hygiene practices facilitate the spread of infectious diseases. The vast majority of diarrhoeal diseases – which cause approximately one quarter of all child deaths in Angola – are linked to unsafe water, inadequate sanitation or insufficient hygiene. Poor water and sanitation conditions have also contributed to repeated outbreaks of cholera (see Section 4.2.1).

Data related to water and sanitation in Angola are available from several surveys including the 2001 MICS, 2006/7 and 2011 Malaria Indicator Surveys, 2008-2009 IBEP and the 2011 QUIBB. Differences in the methodology used by different surveys and limitations affecting samples and data collection make it difficult to construct a detailed and accurate picture of trends and equity in access to water sources and sanitation facilities. The Joint Monitoring Programme for Water Supply and Sanitation (JMP) has attempted to adjust and interpret existing survey data to produce consistent time-series data on select coverage indicators. JMP estimates were therefore used for trend analysis while detailed analysis of the current status of coverage and inequities in coverage uses data from the most recent national surveys (MIS 2011 and QUIBB 2011).

4.5.1 Use of improved water sources and sanitation facilities

In spite of recent advances, JMP estimates indicate that Angola is off-course for achieving the MDG water target and more than a fifth of the population continues to use surface water for drinking. The MDG water and sanitation targets aim to halve the proportion of the population without sustainable access to safe drinking water and basic sanitation between 1990 and 2015. According to JMP estimates, the share of the population using drinking water from improved sources increased from 42 per cent in 1990 to 54 per cent in 2012, far from the MDG target of 71 percent. Furthermore, the JMP estimates that 22 per cent of the national population uses surface water for drinking, virtually unchanged since 1990 (24 per cent). Data from recent national surveys suggested that an even higher proportion of the population relies on surface water: 24 per cent was reported in the QUIBB 2011 and 31 per cent in the MIS 2011.

According to the JMP data, there has been substantial improvement in access to water in urban areas. Figure 4.17 shows a steady increase in urban water coverage from an estimated 43 per cent in 1990 to 68 per cent in 2012. This increase was driven by large investments in the rehabilitation and extension of urban piped water systems since the mid-2000s, resulting in achievement of the MDG target in urban areas.

---

75 It is worth noting that the MICS 2001 was not fully representative at a national level as some parts of the country were not accessible during the war. Also, there have been changes in the categories and definitions used in the different surveys, with IBEP and the QUIBB in particular departing from some standard categories used internationally to define improved water sources and sanitation facilities. There are also inconsistencies in the classification of primary and secondary sources of water, a case in point being the difficulties in classifying the large proportion of water consumed in Luanda that originates from river sources, is transported by tanker-truck and then stored in tanks and sold by retailers in the peri-urban areas.

76 The JMP is a United Nations programme (UNICEF and WHO) that provides globally validated estimates of water and sanitation indicators for all of the world’s countries. For more information see: http://www.wssinfo.org

77 The JMP defines an improved drinking-water source as one that, by nature of its construction or through active intervention, is protected from outside contamination, in particular from contamination with faecal matter.
JMP and survey data do not disaggregate urban coverage data to show the differences between the ‘core’ urban areas and the more disadvantaged peri-urban areas; however local studies show that the use of improved water sources remains very low in most peri-urban areas. In Luanda, where more than a quarter of the total population lives, many households are dependent on untreated river water brought by tanker-trucks and stored and sold at retail level from local tanks in the Luanda slums (musseques). According to the MIS 2011, 22 per cent of the urban population consumes water from tanker trucks and it is presumed that this percentage is considerably higher in Luanda, particularly in the musseques.

Figure 4.16 Trends in use of improved water sources and sanitation facilities by urban and rural areas, Angola, 1990-2012

Source: Joint Monitoring Programme (WHO & UNICEF 2013).

There has been little change since 1990 in access to safe water in rural areas and widespread use of surface water sources remains a major concern in rural areas. According to JMP estimates, rural water coverage in 2012 was 34 per cent, even lower than 42 per cent coverage estimated by the same source for the year 1990 (see Figure 4.16).

The high level of use of surface water sources in rural areas stands out as a major reason of concern. The data on the use of surface water sources in rural areas are fairly consistent across all the sources, falling in the range of 48-51 per cent (IBEP 2008-2009, MIS 2011, QUIBB 2011, and 2011 JMP). Households in rural areas are generally further from drinking water sources: 84 per cent of households in rural areas are within 40 minutes of a drinking water source compared to 94 per cent in the urban areas (QUIBB 2011). Further, fetching water across long distances imposes a heavy burden on women and girls, especially in rural areas.

---

78 Luanda faces particularly serious water supply problems due to the dramatic growth of its population and limited investment in maintenance and expansion of the colonial water supply system over more than 30 years from independence until the end of the war, the development of huge slums without urban planning or provision of services, and the lack of local groundwater sources. Much of the water consumed in Luanda is pumped from the nearby Bengo river.

79 The QUIBB 2011 reports a much lower percentage of the urban population obtaining water from tanker-trucks, but this appears to be because, unlike the MIS, the QUIBB included a category for ‘tank’ (accounting for 29 per cent of the urban population) and most river water brought to the musseques by tanker trucks is deposited first in tanks owned by local retailers before being sold to final consumers (see Cain & Mulenga, 2009).
Angola has made progress in increasing access to safe sanitation, particularly in urban areas. The JMP estimates that use of improved sanitation facilities doubled from 29 per cent in 1990 to 60 per cent in 2012. In urban areas, an estimated 87 per cent of the population used improved sanitation facilities in 2012. Sanitation coverage was boosted by ongoing hygiene education programs conducted by the Government of Angola and its partners in highly populated peri-urban areas.

There has been limited progress in rural areas where access to safe sanitation has grown from an extremely low baseline (7 per cent in 1990): by 2012 only one in five households used safe sanitation facilities (JMP). The 2011 MIS found that rural sanitation coverage was just 16 per cent, lower than JMP estimates. An issue of specific concern is the high proportion of the population practising open defecation, particularly in rural areas. While this proportion has decreased since 1990 (72 per cent), the JMP and the MIS 2011 indicate that 58-60 per cent of the rural population still defecate in open spaces. During the last five years, Government and partners have been working towards improving sanitation in rural areas with a Community Lead Total Sanitation (CLTS) approach, which focuses on behaviour change to end open defecation and increase the demand for improved sanitation facilities, and the development of sanitation markets in rural areas.

National-level data mask large disparities: poor Angolan families have far more limited access to safe water and sanitation than wealthier households. The poorest 20 per cent of Angolans overwhelmingly depend on surface water sources for their drinking water (60 per cent) and practice open defecation (74 per cent). Use of surface water and open defecation decreases as household wealth increases and is almost negligible in the two richest quintiles.

Figure 4.17 Use of surface water sources for drinking and open defecation, by wealth quintiles, 2011

Source: QUIBB 2011.

Poor water and sanitation have severe implications for the national economy stemming from effects on health, use of time, productivity and other factors. Specific data are unavailable on these effects in Angola, but a recent WHO study estimated global economic losses associated with inadequate water supply and sanitation at US$260 billion annually. The same study estimated the average economic return on sanitation spending is US$5.50 for every dollar invested (WHO 2012).

For MDG monitoring, an improved sanitation facility is defined as one that hygienically separates human excreta from human contact.

The JMP estimated urban sanitation coverage at 87 per cent for 2012; however, there is some scepticism about these figures, including in the draft National Environmental Sanitation Policy, which notes ‘strong indications that the coverage rates recorded in the past could be overestimated’ (page 19).

Open defecation is when human faeces are disposed of in the fields, forests, bushes, open bodies of water, beaches, and other open spaces.
4.5.2 Hygiene practices

Poor hygiene behavioural practices are also a reason for concern. Besides the high proportion of people practising open defecation, which is itself partly a behavioural as well as an access problem, other negative behaviours contributing to the spread of disease include the non-treatment of water for drinking and the failure to wash hands after defecating or urinating, or before preparing food or eating. Almost two thirds of all Angolans (62 per cent) who use water from unsafe sources do not treat water for drinking. The proportion is much higher in the rural areas (92 per cent) despite the fact that most rural residents are using surface water, unprotected wells or other unimproved water sources (QUIBB 2011). Hand washing is also not widely practiced, especially in rural areas; only 25 per cent of rural dwellers and 36 per cent of the general population report washing their hands after defecation (IBEP 2008-2009).

4.5.3 Policy challenges for extending and sustaining coverage

The remarkable progress in increasing access to safe water in urban areas is due to large investments of public resources, particularly in piped water systems. The Government of Angola programmed investment expenditure of more than US$1.1 billion in water and sanitation over the period 2007-2016 and as a sector, water and sanitation receives about two per cent of the state budget. Much of the investment has been in large piped water systems for urban areas and small towns, especially the provincial and municipal capitals. There has been some effort to extend these systems to supply community standpipes in the peri-urban areas, however this is technically challenging in many of the larger and more densely populated areas without a broader process of slum upgrading. The Government was conscious of the need to expand access to improved water sources in the rural areas and in 2007 it launched the Água para Todos (Water for All) programme. Budgeted at US$651 million over the period 2007-2012, Água para Todos aimed to provide access to safe drinking water for at least 80 per cent of the rural population by 2012. With strong support from the Presidency, this programme is overseen by an inter-ministerial technical coordination commission and managed at national level by the Ministry of Energy and Water (MINEA) with operations largely decentralized to the provincial governments. Given an extremely low starting point, the coverage target was very ambitious for the short period planned and the programme has since been extended. According to the technical coordination commission data, coverage of improved water sources in rural areas reached 56 per cent by September 2013 (CTCPAPT 2013). Investment has focused on local piped water systems in small rural towns, with 486 of these systems completed and 123 in progress as of September 2013.

Increasing Angola’s overall access to safe water requires improvements in the rural water supply and newly installed piped water systems must be accompanied with the construction of water points in villages. Building on the success achieved with piped water systems, the Água para Todos programme could increasingly focus on water supply in villages, and strengthen coverage through a targeted rural water supply component accompanied by a solid spare parts supply system. Increased access to sanitation in Angola is mainly attributable to improvements in urban areas and rural areas have seen little to no progress in recent years. Virtually all government funding allocated for sanitation represents large investment in networked sewerage in Angola’s cities. Initiatives to improve sanitation in rural areas have come mainly from development partners including the EU, UNICEF and NGOs, working with the Ministry of the Environment (Ministério do Ambiente or MINAMB) and provincial 84

83 Government of Angola coverage statistics differ from JMP estimates because they are based on population estimates, assumptions about the average population coverage of wells and water systems, and the presumption that all existing infrastructure is functioning.

84 Successful experience from other countries in the region and beyond shows that increased national coverage can be achieved by coupling both large water supply systems for cities and towns with a component for rural villages with hand pumps and small water supply solar systems.
governments. Rural sanitation initiatives included the community-led total sanitation (CLTS) approach. CLTS was successfully piloted by UNICEF in Huíla province and the Government has allocated close to US$1 million to expand the programme. It is to be hoped that the Government of Angola will continue to increase funding for the progressive scale up of CLTS.

The approval of the National Environmental Sanitation Policy is urgently required to guide implementation and expansion in the sector. The Ministry’s National Technical Unit for Environmental Sanitation (Unidade Técnica Nacional de Saneamento Ambiental or UTNSA) has been working for some time with the support of an inter-ministerial technical group, to draft a National Environmental Sanitation Policy (Política Nacional de Saneamento Ambiental or PNSA), its approval and adoption will be a key step forward for future development of the sector.

Ensuring the sustainability of water infrastructure in rural areas is a major challenge, requiring community-based approaches to management, and improved technological choices, financing and human resources to operate and maintain water supply systems. In rural areas, where the financial capacity of villagers is low, spare parts are rarely available and institutional capacity is weak, it is crucial to adopt simple and affordable technologies. This has not always been the case, as noted in a 2010 Country Status Overview by the World Bank. While in-depth studies have not yet been conducted, experience in Angola shows that 30 to 40 per cent of water systems fail to operate after the first few years of installation (UNICEF and EU, 2011). There are also concerns that the small piped water systems favoured by the Água para Todos programme in small rural towns may be difficult to sustain, both technologically and financially. To overcome the shortage of skilled personnel in the water sector at local level, a national vocational school is being created by the government with support from the World Bank, the EU and UNICEF.

At the village or community level, a key strategy for improving sustainability is to involve communities in the design and management of water projects from the beginning. The community water management model or Modelo de Gestão Comunitária de Água (MOGECA), has been successfully piloted in both rural and peri-urban areas, but has not yet been scaled up as the standard model for ensuring community ownership and sustainability.

In the urban areas, very low subsidized tariffs benefit mainly wealthier households while leaving the piped water supply systems financially unviable. Along with widespread illegal connections, urban water supply systems cannot meet their operational costs with low tariffs. The state budget has therefore had to finance investments to extend urban piped water systems, as well as cover the operational deficits of these systems. Due to disparities in access to piped water between central and peri-urban areas, the cost of water has also become extremely inequitable. Officially regulated water tariffs paid mainly by residents of the ‘cement’ urban neighbourhoods who are connected to the main network, are much lower than the prices paid by the poorer unconnected households who must purchase untreated water in the peri-urban areas. In 2005, the World Bank estimated that in Luanda, those relying on water from informal sector suppliers pay 20 to 60 times more per cubic metre than networked customers of the Luanda Public Water Company (Empresa Pública de Abastecimento de Água de Luanda or EPAL). A later study reporting the results of a water price survey in all 264 bairros of Luanda, confirmed that extreme differentials remained between official tariffs and informal market prices, and that the latter rose exponentially in the bairros of southern Luanda farthest from the main water source, the Bengo river (Cain & Mulenga 2009).

---

85 Sanitation is institutionally separate from water, with national-level responsibility transferred from MINEA to the Ministry of the Environment, which is also responsible for the sanitation policy and strategy setting.

86 Two of the three types of handpumps officially approved for use in Angola - the Volanta and the Vergnet - cannot be maintained at the community level, and “in any case, no handpump spare parts networks are fully operational nationwide either commercially or publicly, making handpump repair a challenge for local governments and communities alike.” (World Bank 2010, page 28).
Institutional and financial reforms are urgently needed to make urban systems viable and extend coverage to peri-urban areas. The 2002 water law (Law no 6/02) set the foundations for a far-reaching institutional reform of the water sector to tackle these challenges. With subsequent support from the World Bank-financed Water Sector Institutional Development Project, the reform itself was designed providing for the licensing of provincial water and sanitation utility companies, the creation of a regulatory body and tariff reform to ensure financial viability. Although the Government adopted regulations for the new system in 2013, progress in implementation of the reform, including raising official tariffs, has been slow to materialize. The licensing of private operators in the major provincial capitals is ongoing. Given the monopolistic nature of the market the establishment of a strong and independent regulatory body will be crucial. It is likewise important, as provided for in the new regulations, to establish a tariff system that combines the need for financial viability with the need to ensure equitable access, taking into account capacity to pay, including through a social tariff.

In peri-urban areas, experience shows that community-based management of standpipes, linked to the use of robust, low-cost technology and mechanisms for cost recovery, is the most viable model to ensure a sustainable supply of affordable water (Cain & Mulenga 2009). It is also crucial, on an interim basis, to regulate the informal sector water suppliers who will continue to play an important role in transporting, storing and selling water for the peri-urban populations for some time to come, especially in areas where it is technologically difficult to build connections from the mains to community standpipes. It has been estimated that the informal water market in Luanda alone is worth more than US$250 million per year (Cain & Mulenga 2009). At present these suppliers are completely unregulated, with no controls to ensure that the water they sell has been treated.

4.6 Summary of priority actions

To accelerate much needed progress in reducing child mortality, redoubled efforts will be needed across all the dimensions of health and wellbeing discussed in this chapter – the supply and quality of health services, household food security and child nutrition, access to water and sanitation, and families’ health-related behaviours. Similar strategies and commitment, especially to expanding the coverage of health services and maternal nutrition, are crucial for reducing maternal mortality.

An integrated package of high-impact promotional, preventive and curative health services must be scaled up, with special commitment to reaching the poorest families and rural areas, to reduce morbidity and save lives. This package should prioritize the following actions:

- **Strengthening of routine immunization**, in particular through mobile and advanced teams to reach the more remote rural communities, and continued vigilance and mobilisation to prevent the resurgence of polio. Strengthening routine immunization should aim for the elimination of maternal neonatal tetanus and measles, and dramatically scale up coverage of recently introduced pneumococcal and rotavirus vaccines.

- **Expanding the response to malaria** – the leading direct cause of child mortality – through increased coverage of insecticide-treated bed-nets and indoor residual spraying to protect children and their families from malaria. Timely use of artemisinin combination therapy (ACT) must also be scaled up to treat children and reduce mortality from malaria.

- **Expand coverage and improve the quality of maternal health services**, especially in rural areas, to increase the proportion of deliveries taking place in health facilities and ensure the speedy referral and transport of women with at-risk pregnancies to second-tier health facilities with emergency obstetric
services. Maternal health services should also prioritize the promotion of postnatal care at community level for mothers and newborns in the first week after birth to end preventable deaths.

- **Engage with communities to improve health-related behaviours.** The Ministry of Health in collaboration with other key ministries needs to urgently invest in further developing national capacity and support the establishment and progressive scale up of health promotion activities at the community level.

The comprehensive set of nutrition interventions already identified in the national policy documents needs to be translated into operational reality. The following actions should be prioritised:

- **Strengthen and scale up behaviour-change interventions,** particularly targeting early breastfeeding and hygiene practices.

- **Intensify action to combat micronutrient deficiencies,** specifically through increasing the frequency of vitamin A supplementation to two times per year, stronger enforcement of national legislation on salt iodisation, provision of zinc supplements to treat diarrhoea, and routine use of iron folic acid to prevent maternal anaemia. Fortification of staple foods with iron should be considered to address the wider problem of iron deficiencies in children and women of childbearing age.

- **Scale-up the prevention and treatment of acute malnutrition,** through a combination of in-patient facilities for treatment of the most severe cases, outpatient therapeutic programmes and community management by community health workers (ACS), using the CMAM approach.

- **Finally, there is an urgent need to strengthen human resources to deliver nutrition programmes.** More people are needed at central, provincial and municipal levels with qualifications, updated training, and the mandate to work specifically in nutrition. Human resources should reflect the scale of nutrition problems in Angola.

A special effort is needed to scale up the prevention and treatment of HIV and AIDS in children and adolescents as part of a broader drive to contain the disease and its impact. While HIV prevalence in Angola has remained relatively low and stable as compared to southern African neighbours, there is no room for complacency. Knowledge and behaviours are still not conducive to preventing HIV transmission and testing and treatment coverage rates are low, especially among young children. The accelerated response strategy which aims to eliminate new infections in young children by 2015 sets out actions to be taken including rapid and dramatic scale-up of PMTCT, testing and treatment, as well as redoubled communication efforts to improve knowledge and practices.

The PNDS places heavy emphasis on strengthening primary health care (PHC) and promotes integrated approaches to maternal, newborn and child health. Political commitment needs to be realized in practice with the specific objective of achieving equity in health service coverage and health outcomes. Major public investments, backed by improved budget allocations to and within the health sector, as well as policy reforms and large-scale capacity building are needed including:

- **Increased investment in health infrastructure** to extend the PHC network of health posts and health centres, as well as secondary referral facilities in rural areas, especially in the most deprived eastern provinces. New health infrastructure is also needed in the peri-urban areas of Luanda and other large cities where population growth has overwhelmed existing facilities.

- **Training of large numbers of additional health staff and (re)deployment of staff to the provinces in the interior and rural areas in particular,** complemented by design, funding and implementation of an effective system of personnel incentives to redress the imbalances in the territorial distribution of health care workers and improve the quality of services.

- **Measures to end drug stock-outs,** should be set out in the proposed strategic plan for the pharmaceutical sector and implemented with a focus on improving procurement and distribution of essential medicines.
• Establishment of an effective referral system from primary to secondary health facilities. In order to function, the referral system must be based on well-defined and documented set of norms and procedures and have adequate resources for ambulances and other transport.

• Stronger emphasis on proactive outreach to communities to deliver promotional, preventive and curative health services. Effective community outreach can be achieved by investing more in mobile and advanced teams to bring services to remote communities and by scaling up the use of community health workers or agentes comunitários de saúde (ACS), based on a clear set of national guidelines currently under development in the context of a new national policy on ACS. These guidelines must outline the promotional, preventive and curative functions of the ACS and be accompanied by adequate material incentives to reward and retain ACS, the provision of adequate training and retraining, norms for supervision by local health staff, supply of ACS with kits of drugs and other inputs, and mechanisms for referral of patients to health facilities.

• Improvements in public expenditure on health, which in recent years has received low (and declining) budget allocations, does not reflect the priority officially given to PHC in the National Health Policy and the PNDS, and falls short of the target 15 per cent budget allocation articulated in the Abuja Declaration of 2001.

Improving child health and survival also requires a major effort to expand coverage of improved water sources and sanitation facilities, in particular in rural areas and peri-urban slum settlements, to complement the progress made in extending piped water and sewerage systems in the cities and small water systems in rural towns. To this end, high priority should be given to the following actions:

• Give greater emphasis to the drilling and maintenance of village boreholes to tackle the extensive use of surface water sources in rural areas. Solutions for greater coverage of improved water sources should increasingly adopt appropriate technological solutions that recognize practical challenges in rural areas, including water supply solar systems.

• Scale up use of the community water management model in villages and peri-urban communities as the most effective way of ensuring community ownership and the technological and financial sustainability of wells and standpipes. Similarly, strengthen local capacity for proper operation and maintenance of recently installed water supply systems.

• Finalise, approve, disseminate and implement the National Environmental Sanitation Policy as the basis for the development and strengthening of the sanitation sector in the coming years.

• Scale-up community-led total sanitation (CLTS) at the national level and support social marketing of sanitation materials to progressively eliminate the widespread practice of open defecation, which remains a major health hazard especially in the rural areas.

• Implement institutional and financial reforms to make urban water and sanitation systems financially viable and free up resources for extending coverage to the peri-urban areas. Reforms should include tariff reform to ensure equity in the price of water between households with piped water connections and those without, and a strong regulatory body to ensure compliance by water companies with contractual obligations and to protect consumer interests, in particular the equitable access to water by the poor (through a social tariff and cross-subsidization).

In all these areas, communication activities need to be enhanced to improve knowledge and promote behaviours conducive to better health. The promotion of healthier behaviours including improved practices in nutrition and hygiene can contribute significantly to the reduction of health risks and should be given much greater attention than at present. Communication for behaviour change is a vital dimension of strategies to improve the health of the population and of children in particular. Improved communications could be achieved by scaling up and increasing domestic financing of the existing Family Competences Programme, with attention given to both large-scale media campaigns and community-level outreach to families in rural areas where media
coverage is low. Traditional authorities, churches, TBAs and community health workers, schools and social workers will be integral to outreach and communications. Messages should specifically address:

- **Postnatal care** for early detection of danger signs for both mother and new-born.
- **Breastfeeding practices**, including immediate breastfeeding, exclusive breastfeeding during the first six months of life and the introduction of appropriate complementary foods after six months.
- **Knowledge on malaria and the use of insecticide-treated nets** to protect children and pregnant women from malaria, especially in rural areas where basic knowledge on malaria is low.
- **Use of routine immunization services** and in particular adherence by mothers to their children’s vaccination schedules.
- **Hygiene practices** including awareness of the importance of improved sanitation for health and the survival of children, and promotion of hand-washing and treatment of water, especially among the poor and in rural areas.
- **Reproductive and sexual health**, to delay sexual debut, reduce teenage pregnancy, increase birth spacing, reduce fertility, raise awareness of the importance of antenatal consultations and facility-based deliveries, and to improve protection against the transmission of HIV and other sexually transmitted infections.
Chapter 5.

Education: Giving children the tools to thrive

Education is a fundamental human right guaranteed by the Constitution of Angola, and crucial for the economic and social wellbeing of the population and the long-term development of the country. Education boosts economic growth and reduces poverty by increasing human capital and improving labour productivity while strengthening the innovative capacity of the economy (Hanushek et al., 2010). Higher levels of educational achievement are associated with greater gender equality and levels of social participation. By improving access to information and knowledge, education is also integral to better health and nutrition and is associated with greater financial capacity of households. The long term development strategy ‘Angola 2025’, articulates a vision of education as one of the motors of economic and social development within the overarching objective of promoting access by all Angolans to productive and remunerative employment and maximizing the value of human resources (MINPLAN, 2004).

Over the last decade Angola has made great strides in increasing access to education, however further progress is required to tackle inequalities in access as well as to improve the quality of education. The number of pupils enrolled in all levels of schooling increased more than fourfold from 2.2 million in 2001 to 9.5 million in 2014. Progress to date in expanding access at various levels of the education system including literacy and ‘second chance’ education for adolescents and adults is assessed in Sections 5.1-5.4 along with the limits of this expansion and in particular, the disparities in access that curtail opportunities for children from poorer families and in rural areas. Sections 5.5-5.7 address quality and efficiency in education, issues that provoke growing interest amid concerns about poor learning achievement and high rates of repetition and dropout. Finally, the economic, sociocultural and other factors that limit demand for education are analyzed in Section 5.8, looking in particular at the reasons children are starting primary school after the official age of 6 and then dropping out before they complete primary school.

5.1 Early childhood development (ECD) programmes

Participation in ECD programmes by children under 6 remains low. The last nationally representative data from IBEP 2008-2009, showed that only 9.3 per cent of children aged 3-5 attended pre-school ECD programmes, far below the target of 30 per cent set in the 11 Commitments for Children. ECD participation rates were higher in urban than rural areas (11.6 per cent compared with 7.6 per cent) and associated with household wealth, with attendance increasing from 6.8 per cent of children in the poorest quintile to 16.5 per cent of children in the wealthiest quintile. Parents and guardians whose children did not attend ECD programmes gave three main reasons for this: children were considered “too little” to attend school (38 per cent), there was no available programme (38 per cent) or available ECD programmes were too expensive (15 per cent) (see Figure 5.1). In 2012, just 40,720 children – equivalent to 1 per cent of the estimated population aged 0-5 – attended ECD centres run by the social welfare ministry (MINARS).\(^8\)

\(^8\) Centros Infantis Comunitários (CIC) and Centros Educativos Comunitários (CEC). See the Strategy for the Expansion of Care and Education in Early Childhood Development (Estratégia de expansão da rede de educação e cuidados da primeira infância) (MINARS 2013).
Pre-primary grade zero (iniciação) has a high level of gross enrolment, but enrolment includes many older children contributing to concern over the quality of classes. Iniciação is attached to regular primary schools and is intended to receive children aged 5. Administrative data from the Ministry of Education (Ministério da Educação or MED) show enrolment in iniciação increased from 237,208 in 2001 to a peak of 938,389 in 2007 and then declined in 2014 to 645,258. The surge in enrolment in the early to mid-2000s reflected the Government’s decision to make iniciação a core part of the basic education system. However, public investments have not been adequate and shortages of appropriate classrooms and specialized pre-primary teachers negatively affect the quality of education at this level. Poor quality facilities and teaching may have contributed to the decline in enrolment in iniciação since 2007, although this trend may also be due in part to tighter observance of age requirements which would have reduced the number of over-age children enrolling in iniciação. The gross enrolment rate in iniciação was estimated at 100.1 per cent in 2014, suggesting that many children in this class are still likely to be older than 5 years.

Ongoing improvement to the supply and quality of ECD programmes is a crucial priority as investments in early childhood education have a very high return, improving pupils’ success in primary school and beyond. The allocation to pre-school education in the 2014 state budget was just US$3 million. This amount is insufficient to achieve the major expansion of pre-primary education envisaged in the new Education for All National Action Plan (Plano de Acção Nacional - Educação para Todos or PAN-EPT) for 2013-2020. ECD is the focus of one of six core objectives set out in the PAN-EPT, to “expand and improve, in all aspects, early childhood care and education, especially for the most vulnerable and disadvantaged children” (page 71). The PAN-EPT sets ambitious targets to increase ECD coverage to 50 per cent among children in the age group 0-3 years and 70 per cent in the age group 3-5 years by 2020.

5.2 Participation in primary and secondary education: growth and inequity

Angola has made major strides in expanding pupil enrolment at all levels of education, however further improvements are required to increase the number of pupils reaching secondary school. According to MED data, between 2003 and 2014 the total number of pupils rose by 108 per cent in primary education (grades 1-6), by 470 per cent in the first cycle of secondary education (grades 7-9) and 281 per cent in the second cycle of secondary education (grades 10-12 or in some cases 10-13). The increase in absolute numbers resulted in increased net attendance ratios (NAR) at both primary and secondary levels.89 According to national

---

89 Net attendance ratio (NAR) is the number of pupils in the official age group for a given level of the education system who attend school at that level, expressed as a percentage of the official age-group population. The gross attendance ratio (GAR) is the total number of pupils of any age who attend school at a given level of the education system, regardless of age, expressed as a percentage of the population in the official age group corresponding to that level of education.
survey data, primary NAR (defined as the proportion of children aged 6-11 in classes 1-6) rose to 76 per cent in 2008-2009 and 79 per cent in 2011. Secondary NAR also increased from a much lower baseline of 19 per cent (for children aged 12-17) in 2008-2009 to 28 per cent (for children aged 12-18) in 2011 (IBEP 2008-2009, QUIBB 2009)\(^90\).

Remarkable increases in pupil enrolment were achieved through substantial government investment in school infrastructure and teacher recruitment and deployment. During the period 2003-2014, a total of 42,231 primary and secondary school classrooms were built and since 1975 more than 63,000 primary education teachers were recruited (MED 2014). Major investments in teacher training were made to increase the quality of teaching. Intensified effort is required at the secondary level where net attendance remains low (28 per cent) when compared to secondary NAR in other SADC countries (see Chapter 3, Figure 3.3). Although an additional 8,737 classrooms (MED 2014) for secondary education have been built since 2003, the number of secondary schools has not kept up with rapidly growing numbers of pupils.

The proportion of children who start school late is declining, although it remains high. Historically, one of the reasons for low primary NAR has been the delay in children enrolling in grade 1 by the official age of 6. In 2014, only 30.6 per cent of 6-year-old children were in grade 1 (MED 2014). The reasons for late entry are discussed later in Section 5.8. Along with the repetition of grades, late entry contributes to a high proportion of over-age children and youth in the school system. For example, the IBEP found that no less than 58 per cent of children of secondary school age (12-17 years) were still attending primary school. Being older increases risk of dropout as the opportunity cost of school is much higher for adolescents who might otherwise be working, than for younger children. Late starters and repeaters may also undermine the quality of education as teachers struggle to teach the same curriculum at the same pace to learners of different ages and levels of cognitive development.

Low rates of completion of primary school and transition to secondary school is an issue that requires urgent attention. Data from MED (2014) indicates that 78.1 per cent complete primary education, which is a national average. However, there are marked regional differences. MED data in 2010\(^91\) shows gross primary completion rates varying from a very low 10 per cent in Bié to 46 per cent in Kwanza Sul. Angola has one of the lowest rates of gross primary completion in Sub-Saharan Africa (see Chapter 3). Besides the significant proportion of children who never go to primary school – estimated at 7 per cent in 2008-2009, a large number of those who enter primary school drop out before they finish the 6-year course – an issue taken up in more detail in Section 5.6. Of those who complete primary education, only 60 per cent enrol in secondary school (MED 2013).

Major inequities in education are seen between urban and rural areas and different wealth groups; poorer and rural children are far less likely to be enrolled in school, especially at the secondary level. Primary NAR was markedly lower in the eastern provinces of Moxico (59 per cent) and Lunda Norte (56 per cent) and in Bengo in the northwest (56 per cent). Children in rural areas have significantly lower net attendance in primary school (72 per cent) than children in urban areas (85 per cent) and poorer children are also less likely to be enrolled in school. In the poorest quintile, primary NAR was just 67 per cent as compared to 89 per cent in the wealthiest quintile (see Figure 5.2). At secondary level, disparities are magnified; secondary NAR in urban areas (44 per cent) is more than five times higher than in the rural areas (8 per cent) and less than one in ten children aged 12-18 from the poorest households are in secondary school as compared to 4 per cent in the first wealth quintile and 8 per cent in the second quintile (QUIBB 2011). Put another way, children born

\(^{90}\) A comparison with the MICS 2001 data is difficult because primary education at the time lasted for only 4 years (officially for ages 6-9) and the survey was not nationally representative due to lack of access to conflict-affected areas. However, these factors suggest that the primary NAR in 2011 (under current definitions) would have been much lower than the reported MICS figure of 55.8 per cent.

\(^{91}\) MED 2011 report providing disaggregated data by province for Benguela, Bié, Cunene, Huambo, Huila, Kwanza Sul and Namibe.
into poorer households and especially in rural areas, are exceedingly unlikely to reach or progress in secondary school, whatever their aptitude for learning. Such extreme inequity in education not only impacts children’s life chances but leaves huge human potential untapped in Angola.

**Figure 5.2 Net attendance ratios for primary and secondary education, by quintiles and areas of residence, 2011**

![Net attendance ratios](source: QUIBB 2011)

Children who are orphans are much less likely to be in school, particularly those who have lost both parents. One in a hundred children in Angola (0.9 per cent) have lost both their parents and only 74 per cent of double orphans aged 10-14 are in school, compared with 86 per cent of all children in this age group (See Figure 5.3). Among double orphans, girls are especially vulnerable to exclusion from school; only 64 per cent of double-orphan girls in the 10-14 year age group are in school compared to 85 per cent of double orphan boys and an average of 83-86 per cent for girls in the general population.

**Figure 5.3 Percentage of double orphans and of all children aged 10-14 attending school, Angola, 2008-2009**

![Percentage of orphans and all children](source: IBEP 2008-2009)
Although enrolment in special education has increased, very few children with disabilities and special needs have access to schools. Official policy promotes the integration of these children into normal schools wherever possible. However, some children with severe disabilities do require special education. Though special education has undergone considerable expansion in the past decade, with the number of children enrolled rising fivefold from 4,357 in 2001 to 31,762 in 2014 (MED), children in special education still account for a small portion of all children in primary education. Information about the quality of special education or learning achievements among children with special learning needs in Angola is insufficient to make further analysis.

Angola has nearly achieved gender parity in primary education, but it is still the case that fewer girls than boys attend primary school, especially in the rural areas. At primary level, the gender gap between girls and boys has almost disappeared. In 2011, the gender parity index (GPI) – measured as the ratio of NARs for girls to boys – was 0.98 in both urban and rural areas. At secondary level, more serious gender inequity persists driven largely by disparities in rural areas. National GPI is 0.93 and urban GPI is 0.97 while in rural areas, GPI plummets to 0.54. Only 6 per cent of rural girls aged 12-18 attend secondary school compared to 11 per cent of boys. While gender equity cannot be overlooked, the more urgent concern is that few children of either sex attend secondary school in rural areas.

Figure 5.4 Net attendance ratios for primary and secondary education, by gender and area of residence, 2011

5.3 Literacy and opportunities for ‘second-chance’ education

Angola has made substantial progress in fighting illiteracy. Historical rates of adult illiteracy were startlingly high; estimates indicate that only 15 per cent of adults aged 15 and over in 1975 could read and write. However projections for 2015 estimate the adult literacy rate at 71 per cent\(^\text{92}\) (UNESCO 2014), attesting to sustained improvements in access to education and investments in literacy programmes, teacher training and the production of didactic materials. Unfortunately, men and women have not benefitted equally and the projected literacy rate for women (61 per cent) lags substantially behind that of men (82 per cent) (UNESCO).

\(^{92}\) The most recent survey data available in Angola, is from the QUIBB 2011 which found an adult literacy rate of 66 per cent.
While overall literacy rates have increased, illiteracy remains a concern, particularly in rural areas, among women, and in the poorer quintiles. In 2011, the last national survey measuring literacy found that 31 per cent of the population aged 15 and above is illiterate, a small decrease from 34 per cent measured in 2008-2009 (QUIBB 2011, IBEP 2008-2009). Historical gender disparities in education resulted in illiteracy rates that are more than twice as high among women than among men, and in rural areas no less than 70 per cent of women are illiterate (see Figure 5.5). Illiteracy has serious consequences particularly for poor rural Angolans and women, limiting their options for income-generation to traditional low-skill occupations such as subsistence farming and petty trade, thereby also restricting their participation in broader economic growth and development. Further, illiteracy constrains access to information and the acquisition of important life-skills and knowledge, including in areas such as child care, nutrition, health and hygiene.

In 2007, the Government adopted a strategy to strengthen literacy training and provide opportunities for adolescents and youth who left school early to return to their education. The strategy provided for financial and technical support for training of trainers and for the production of training and learning materials. The government also launched a literacy and adult education programme – the Programa de Alfabetização e Aceleração Escolar (PAAE) – in partnership with several civil society organizations. Overall, enrolment in literacy and adult education programmes increased reaching 731,278 in 2014 with an even higher number of students – 1.3 million – involved in post-literacy activities (MED 2014). Considering this recent data the PAAE would cover more than one third of the adult population unable to read and write, estimated at 3.3 million in 2011. An evaluation of the PAAE reported considerable success in providing opportunities for adolescents and youth to return to education however the programme has not been sufficient to decongest regular primary schools, where there are still large numbers of over-age children (UNICEF 2013a). Furthermore, the programme has been less successful in enrolling adolescents who never attended primary school (as opposed to those who enrolled and subsequently dropped out). The evaluation also expressed concern that the duration of the curriculum was too short to consolidate literacy, creating the risk of a return to illiteracy.

Figure 5.5 Adult literacy rates (aged 15 and above) above by gender and area of residence, Angola, 2011


Note that minor discrepancies in adult literacy statistics are due to the data source presented. UNESCO projections for 2015 reported in the Education For All global Monitoring Report 2013/14 account for existing national data and trends. Data on urban-rural disparities in literacy rates are drawn from the QUIBB 2011. Both sources confirm significantly higher rates of literacy among men in Angola.
5.4 Professional and technical education: equipping adolescents to enter the labour market

Given low rates of secondary enrolment, it is crucial to provide education options that equip adolescents and youth with the skills they need to enter the labour market. Policies and programmes in this area are the responsibility of two ministries, the Ministry of Education and the Ministry of Public Administration, Labour and Social Security (Ministério da Administração Pública, Trabalho e Segurança Social or MAPTSS), whose respective roles are not clearly demarcated. Technical and Vocational Education (TVE) under the Ministry of Education is subdivided into two cycles: basic vocational training (level II) and middle level technical training (level III)\(^4\); the latter is accessible to students who have completed the ninth grade.

MAPTSS is responsible for the functioning of the National Service of Vocational Training (Serviço Nacional de Formação Profissional or SNFP), which is overseen by the National Institute for Labour and Vocational Training (Instituto Nacional de Emprego e Formação Profissional or INEFOP)\(^5\) and has four specific objectives:

- Improve the initial vocational training of young people and adults in all economic sectors, including the informal sector;
- Support further training, refresher training and retraining of the labour force;
- Boost vocational training for most disadvantaged and vulnerable groups;
- Promote the training of trainers, managers and middle level managers.

The number of students enrolled in technical-professional education increased four-fold from 37,500 in 2001 to 147,750 in 2014 (MED) of which about 50 per cent enrolled in professional training schools under the oversight of the INEFOP. Most of those students in INEFOP training schools are enrolled on short-term courses and about half of the students who successfully graduated during the period 2009-2011 (66,297 out of 133,119) took courses in computing. It is not known how successful the graduates of these various programmes have been in obtaining employment and using their skills on the job. According to a review of the PAN-EPT one of the weaknesses of these programmes has been a lack of dialogue with employers about training needs (MED 2011). Both the MED and MAPTSS programmes are also overwhelmingly concentrated in the urban areas. The effectiveness of vocational training could be strengthened by ensuring that it is increasingly demand-oriented and maintains stronger links with the labour market that will ultimately provide employment opportunities to trainees.

5.5 Learning achievement and education quality

The quality of education – and by extension, learning outcomes – remains an area of concern. Huge increases in the number of pupils, wide age mix in classrooms and inadequate inputs have all put huge pressure on the education system, undermining what matters most: students’ learning. Poor cognitive development of preschool age children as a result of under-nutrition and micronutrient deficiencies (see Section 4.3) and the lack of a supportive home environment for studying may also weaken learning outcomes. An assessment of grade 2 pupils carried out in 10 provinces in 2006 found that a high proportion of pupils had not attained the basic skills in mathematics and in reading and writing in Portuguese that are

\(^4\) Level II starts after primary education (sixth grade compulsory education) and provides a ninth grade equivalence. Level III lasts three years, is equivalent to the twelfth grade and depending on a set of pre-defined criteria, allows students access to higher education.

\(^5\) The decentralised structure of INEFOP comprises 18 Employment and Vocational Training Units, 45 Employment Centres, 29 Training Centres, 9 integrated centres for employment and vocational training, 1 vocational rehabilitation centre, 59 Arts and Crafts Pavilions, and 55 mobile vocational training workshops for training in remote areas. INEFOP also oversees 1 technology training centre (CINFOTEC), 1 National Centre for training of trainers (CENFOR), 1 Hotel and Restaurant training school, and Rural Arts and Crafts schools. In addition, there are approximately 360 Private Centres, licensed by INEFOP, which offer vocational training courses mainly in the tertiary sector.
It is worth noting that reducing costs will not improve cost-efficiency if the quality of education is undermined, leading to failure, dropout and repetition. In fact, reducing overall costs could increase the cost per graduating pupil if it takes more pupil-years to produce a graduate.

Benguela, Bié, Cunene, Huambo, Huíla, Kwanza Sul and Namibe.

Expected of pupils who have completed grade 1 (MED, INIDE & ADPP, 2006). In the poorest performing province (Cunene) only about one third of grade 2 students passed grade 1 level mathematics and reading and writing exams (see Table 5.1).

Investments in assessment of school quality and learning achievement is critical to monitor the performance of the education system and enable corrective measures to be taken, particularly in early grades. At the moment, the education sector does not have a systematic performance and evaluation system for regular measurement of learning results. Although the provinces organise primary and secondary school examinations, exam results are not used for analysis and review of teacher performance and curriculum. Investment in assessment in education is paramount not only because it measures the performance of programmes and promotes judicious use of resources, but because it will also help identify and disseminate best practices. Angola recently joined the Southern African Consortium for Monitoring Educational Quality (SACMEQ) and with the start of ‘Learning for All’, a World Bank-supported education project for 2013-2017, positive steps are being taken towards the adoption of formative and regular assessments of teacher and student performance.

Table 5.1 Learning achievement: % of grade 2 pupils passing reading/writing and numeracy tests based on grade 1 curriculum, 2005

<table>
<thead>
<tr>
<th>Province</th>
<th>Reading/writing</th>
<th>Numeracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bengo</td>
<td>46%</td>
<td>55%</td>
</tr>
<tr>
<td>Benguela</td>
<td>50%</td>
<td>64%</td>
</tr>
<tr>
<td>Cabinda</td>
<td>53%</td>
<td>65%</td>
</tr>
<tr>
<td>Cunene</td>
<td>37%</td>
<td>33%</td>
</tr>
<tr>
<td>Huambo</td>
<td>63%</td>
<td>70%</td>
</tr>
<tr>
<td>Huíla</td>
<td>65%</td>
<td>52%</td>
</tr>
<tr>
<td>Luanda</td>
<td>58%</td>
<td>75%</td>
</tr>
<tr>
<td>Lunda Sul</td>
<td>68%</td>
<td>74%</td>
</tr>
<tr>
<td>Malange</td>
<td>46%</td>
<td>56%</td>
</tr>
<tr>
<td>Uíge</td>
<td>44%</td>
<td>48%</td>
</tr>
</tbody>
</table>


5.6 Efficiency of the education system

Improving the efficiency of the education system is a key priority. Education efficiency is measured as the conversion of inputs such school buildings, teachers, inspectors and materials into education outputs such as pupils completing various levels of the school system and learning results. To maximise cost-efficiency, an optimal balance must be struck between the cost of these inputs and the output of the system. High levels of grade repetition entail the need for more trained teachers. It is therefore particularly important to monitor the proportions of pupils who are successfully advancing to the next grade as compared with those who are repeating grades or dropping out. Accurate national data on repetition and drop-outs were not available for this analysis, but administrative data from 2010 covering seven provinces shows that

---

96 It is worth noting that reducing costs will not improve cost-efficiency if the quality of education is undermined, leading to failure, dropout and repetition. In fact, reducing overall costs could increase the cost per graduating pupil if it takes more pupil-years to produce a graduate.

97 Benguela, Bié, Cunene, Huambo, Huíla, Kwanza Sul and Namibe.
the overall promotion rate in primary education for these provinces was just 72 per cent, while 12 per cent of students failed and 16 per cent dropped out. Of enrolled pupils, 11 per cent were repeating a grade (MED 2011a). Supply and demand-side factors contributing to the high rates of repetition and dropout are discussed in Section 5.8.

The education reform introduced automatic promotion in grades 1, 3 and 5 as a strategy to reduce repetition and dropout. The Ministry of Education states that promotion rates have improved dramatically from 47 per cent before the reform to 80 per cent after the reform was enacted (MED 2013), while reducing the repetition rate from 27 per cent to 10.8 per cent and the dropout rate from 27 per cent to 11.1 per cent (MED 2014). The education reform is discussed more fully in Section 5.8.

5.7 The education reform and supply-side bottlenecks

Following the adoption of the Education System Basic Law in 2001, the Government has sought to improve the performance of the education system through a far-reaching education reform which has been implemented in stages since 2004. The 2001 law increased the length of primary education from four to six years while the reform was designed to expand the school network and improve the quality of teaching and effectiveness and equity within the system (INIDE 2009). Decree No 2/05 of 14 January 2005 set out a timeline for the progressive implementation of the reform, covering stages of preparation, piloting, evaluation and nationwide roll-out of revised curricular content, teacher training and textbooks for each grade of the new system. The reform also introduced automatic promotion in grades 1, 3 and 5, as noted above, a mechanism for continuous assessment of pupils, and a new system of monodocência, by which a single teacher was expected to teach all the subjects in a primary school grade. A Master Plan for Teacher Training, for the period 2008-2015 aimed to improve pre-service and in-service training of teachers.

Implementation of the reform has been beset with difficulties, limiting its effectiveness. A study in Luanda, Huambo and Huíla, observed that after six years of progressive implementation of the reform, “... serious problems appear to be persisting, regarding the innovativeness and quality of education proposed by the education reform” (Azancot de Menezes 2010). Several problems were highlighted including: (1) lack of trained primary school teachers and lack of teachers with training to teach specific subjects introduced by the reform, (2) shortage of classrooms and assessment tools, and (3) crowded classrooms. Continued efforts by the Government of Angola to provide funding and technical assistance as well as demonstrated political commitment will undoubtedly help to mitigate some of the difficulties faced in implementation of education sector reforms.

Increased investment in school infrastructure is required to meet the needs of a growing number of pupils. Despite large investments in school construction, the availability of classrooms has not kept pace with the rapid increase in the number of students, leading to large class sizes, double and triple shifts, and shortened contact hours. Students have an average of only three hours of teacher-contact a day (MED, UNICEF & IICE 2011). Education data from seven provinces show that on average, two or three shifts a day are used to teach almost all primary and secondary grades (MED 2011a). In rural areas, many classes are held outdoors under trees for lack of classrooms (Azancot de Menezes, 2010) and the number of pupils per classroom has actually worsened since 2008, reaching 104 pupils per primary school classroom in 2014 (MED) (see Figure 5.8). The pupil-classroom ratio is even higher in secondary education: 159 in the first cycle and 194 in the second cycle in 2012 (MED 2013). Few primary schools have libraries, laboratories or sports facilities (Azancot de Menezes 2010; MED & UNICEF). There are also large shortages of desks and seats for pupils, and many schools do not have water sources or toilets, let alone computers.
Expansion of the network of rural schools is crucial to reduce the distances children must travel to reach school, a major barrier to children’s attendance in rural areas. One third (33 per cent) of the rural population lives more than 40 minutes from the nearest primary school (QUIBB 2011). Physical access to secondary education is even more difficult particularly in rural areas, contributing to very low enrolment of children at secondary level. In 2011, 80 per cent of the rural population lived more than 40 minutes away from the nearest secondary school. These data are a reminder of the importance of continued investments to expand the network of primary and secondary schools based on a careful assessment of catchment areas and populations of school-age children.

Classroom construction also needs to be scaled up in urban areas, where many schools are heavily overcrowded due to high urban population density and rapid growth of the school-age population. Building more classrooms would make it possible to move gradually towards ending the system of double and triple shifts and increasing the contact time between teachers and pupils, a crucial step to improve education quality, performance and learning outcomes.

Another top priority is to invest more in training teachers, whose numbers, training, motivation and contact time with pupils are the most important determinants of the quality of education. The Government has succeeded in substantially increasing the number of teachers entering the system, keeping pace with the rapidly growing number of students and maintaining a stable pupil-teacher ratio of 33-37:1 in recent years (see Figure 5.6). At secondary level, there seems to be a surfeit of history and geography teachers, but for other subjects there is a shortage (MED 2014). A crucial area of concern at both primary and secondary levels is the quality of the teaching and teachers’ limited contact time with pupils due to the shift system, absenteeism and the late start of classes.

Large numbers of working teachers are untrained. Many teachers still need to receive pre-service training and have no access to in-service training, while some have not even completed a full cycle of basic education. Data available from six provinces in 2010 (MED 2011a) show that 32 per cent of teachers in iniciação, 27 per cent of teachers in primary school, 10 per cent in the first cycle of secondary school and 12 per cent in the second cycle of secondary school had no teacher training (see Table 5.2).
Table 5.2 Teacher training: Percentage of all teachers without training by level in six provinces of Angola, 2010

<table>
<thead>
<tr>
<th></th>
<th>Benguela</th>
<th>Cunene</th>
<th>Huambo</th>
<th>Huila</th>
<th>Kwanza Sul</th>
<th>Namibe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iniciação</td>
<td>29.0</td>
<td>43.6</td>
<td>20.5</td>
<td>37.7</td>
<td>42.2</td>
<td>31.3</td>
<td>31.7%</td>
</tr>
<tr>
<td>Primary</td>
<td>25.4</td>
<td>31.9</td>
<td>16.3</td>
<td>33.1</td>
<td>8.4</td>
<td>20.3</td>
<td>27.0%</td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>10.3</td>
<td>16.7</td>
<td>12.7</td>
<td>6.3</td>
<td>8.3</td>
<td>9.5</td>
<td>10.0%</td>
</tr>
<tr>
<td>II</td>
<td>9.3</td>
<td>36.5</td>
<td>8.5</td>
<td>6.4</td>
<td>9.2</td>
<td>35.6</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

Source: MED 2011a.

The expansion of teacher training, including in-service training for unqualified teachers, is a high priority. Under the Master Plan for Teacher Training 2008-2015, the Government has expanded the number of teacher training colleges (part of the second cycle of secondary education), increasing capacity to provide pre-service training for a new generation of teachers. The number of students enrolled in teacher training colleges more than doubled since 2001 from 37,447 to 59,525 in 2012. However, in-service training is needed for the cohort of teachers who were recruited without prior training, as well as to meet the demands placed on all teachers by the extension of the length of primary school to six years and changes in the curriculum brought in under the education reform. In-service training should be provided through pedagogical influence zones (Zonas de Influência Pedagógica or ZIPs), a system whereby a centrally located school or a selected resource centre provides capacity building support to all schools within a designated zone. The present efficacy of the ZIP system varies substantially from one province to the other.

School directors need training to improve the management and increase the autonomy of schools as envisaged by the education reform and the PAN-EPT. In the case of secondary schools, directors need to strengthen their capacity to receive and manage public funds. Management support should also focus on strengthening the links between schools and the communities they serve, with the objective of improving community participation in school affairs, particularly through the committees Comissões dos Pais e Encarregados de Educação (CPEE).

While teacher training is a crucial starting point, teachers need encouragement, support and incentives to perform well, particularly in challenging environments. Evaluation reports have highlighted low levels of job satisfaction among some teachers and school directors due to reasons such as poor salaries (despite a modest improvement over the past decade) and delays in the payment of salaries, as well as limited opportunities for in-service training, difficult teaching conditions in schools and poor resources (Azancot de Menezes 2010). Rural teaching posts are often difficult to fill for a number of reasons including: (1) challenging living conditions and limited services in rural areas, (2) lack of either financial incentives or decent housing for teachers. Many teachers assigned to rural schools continue to live in the provincial or municipal capitals and travel daily at their own expense to reach their schools. Due to the irregularity and difficulty of transport, they may often arrive late, reducing the length of shifts and contact time with pupils. It is crucial to develop adequate strategies to attract and retain teachers in rural areas and address the transport issues that cost classroom time. Some strategies could include: (1) providing teacher housing within rural communities, (2) hiring and training of local teachers, (3) providing reasonable relocation grants for teachers who are willing to relocate and teach in rural areas governed by terms clearly articulated in a binding contract, and (4) providing reliable subsidized transportation for teachers who live in cities but are willing to commute to rural areas and teach.

MED, 2012.
The education reform introduced substantial changes to the school curriculum; there is however a need to ensure that teachers are adequately prepared to implement these changes. A new curriculum for each grade of primary and secondary education with corresponding textbooks was rolled out over several years starting in 2004. In addition to core subjects, such as Portuguese and Mathematics, the new curricula introduced material on subjects such as HIV/AIDS and the environment, music, sports and work education. However, the in-service training that was provided has been inadequate to help teachers cope with the demands of the reformed curriculum. Many teachers also found it difficult to meet the requirement to teach across the full spectrum of subjects (monodocência).

Production and distribution systems for school textbooks need to be strengthened. Textbooks are supposed to be distributed free to pupils, however, the Ministry of Education has noted “weak production and distribution capacity for textbooks, school furniture and school materials” and not all students have access to adequate learning materials (MED 2011b). In 2011 it was reported that the provinces received just over half (52 per cent) of the number of textbooks that had been ordered from the national level. Students’ academic success inherently depends on their access to quality learning materials. Regular monitoring and assessment of the textbook distribution process is urgently required to ensure that all pupils receive required textbooks. This goal can be achieved through the enforcement of the existing law and regulations pertaining to textbook distribution.

Approximately half of children speak Portuguese as their mother tongue and while some efforts have been made to accommodate children who speak local languages, there is a need for a more systematic approach to bilingual education. The exclusive use of Portuguese as medium of instruction puts children brought up speaking local African languages at a distinct disadvantage in school. The right to education for every child was reaffirmed by article 9 of the Education Basic Law of 2001. The Ministry recently initiated research on the enrolment of children from migrating populations and there are a number of projects in Angola piloting instruction in local languages with the gradual introduction of Portuguese. However many challenges to systematizing bilingual education remain including (1) difficulties in identifying teachers who speak the local language and (2) lack of specific learning materials in the local languages for the early grades of primary school. These gaps in bilingual education present a major obstacle and hinder learning for young children who are not native Portuguese-speakers. As most of these children are rural and from poorer families, the lack of systematic bilingual education reinforces patterns of inequality in education and beyond.

Primary schools do not receive direct budget transfers and often struggle to meet their operating costs without recourse to contributions from parents and guardians. There is as yet no system for providing primary schools with capitation grants or similar transfers, as in countries like Ghana and Mozambique, to offset the official suppression of school fees (see Section 5.8). This leaves many schools with no option but to raise funds from children’s families in order to meet basic operating costs such as repairs and maintenance or the payment of cleaners and security guards. Secondary schools have been recognized as budget units and receive direct transfers from the Ministry of Finance. The primary schools are supposed to receive support in the form of materials from the provincial directorates of education or repartições municipais de educação (RME), but this support seems to be rare in practice and/or is inadequate to real needs (Azancot de Menezes 2010; MED & UNICEF). The Government of Angola is considering the establishment of an integrated regulation for primary and secondary schools which covers the provision of finance, learning and teaching materials, school feeding and transport. Successful implementation of this regulation would be a very important development for the sector and could substantially improve the management of schools at all levels.

The revised National Plan of Action for Education for All (PAN-EPT) is a comprehensive plan for the period 2013-2020 which reaffirms “the strategic role of education as a human right and as a vehicle for poverty reduction and the attenuation of social inequalities and as an essential condition for the sustainable development of the country” (MED 2013, page 68). The Plan has six objectives:

Chapter 5. Education: Giving children the tools to thrive
1. Expand and improve early childhood education;
2. Achieve universal free access to and universal completion of primary education by 2020;
3. Provide adequate and lifelong equitable learning opportunities to equip youth and adults for an active life;
4. Increase the number of literate adults, in particular women, by 50 per cent by 2020;
5. Eliminate gender disparities in primary and secondary education by 2017 and achieve full gender equality in education by 2020;
6. Improve the quality of all levels of education, in particular for literacy, numeracy, and life skills.

Effective implementation of the PAN-EPT requires greater efforts to strengthen the education management information system, and address the shortage of trained managers as well as the diffusion of responsibilities between different administrative levels. Weaknesses in the education management information system (SIGE) hinder effective planning, monitoring and evaluation in the sector. SIGE was piloted by the Project for Support of Primary Education or the Projecto de Apoio ao Ensino Primário (PAEP) in eight provinces and is to be scaled up nationally, with investments in technology and human resources, to produce reliable education statistics. Data from SIGE and the 2014 population census, along with a planned mapping of school infrastructure, should provide a sound evidence base for prioritizing investments in the expansion of the school network. However, effective planning and monitoring are also hindered by low numbers of qualified staff in the provincial and municipal education structures and by the fact that very few school principals have any management training. The specific form that ‘deconcentration’ has taken in Angola also complicates the development of a coherent system of sector planning, management and financing. In practice, certain operational functions and some investments have been moved to provincial governments, while leaving overall policy and planning within the national MED. Funds for operations also flow through the provincial governments and therefore the level of provincial financing for education depends on the degree of priority given to education by each provincial government, and by the governors in particular. MED has no vertical authority over the DPE and RME, except as the source of policy, norms and regulations (MED, UNICEF & IICE 2011). Some other aspects of the system remain centralized. For example, the Ministry of Finance pays all salaries, INIDE produces and distributes textbooks and MED finances some investments. In this complex system, it is difficult to ensure coherence and equity in the planning and financing of education development.

Public expenditure on education should be increased at least to the level of other African countries with large school-age populations. Overall, education was allocated 7 per cent of the state budget (excluding debt service) in 2014, continuing a steady decline since 2011 when education spending was budgeted at 11 per cent. Recent data on actual executed expenditure on education is unavailable, but was estimated in 2008 at 7 per cent of total government expenditure (MINFIN 2009). By comparison, education receives more than 20 per cent of spending in many African countries99 and Angola is the only African country to spend less than 10 per cent (UNESCO, 2011). Measured in purchasing power parity US dollars, public expenditure per primary pupil in Angola in 2006 was $181, just over one tenth of the level in Botswana ($1,574 in 2007), one sixth the level in South Africa ($1,325 in 2007) and one fifth of the level in Namibia ($1,325). There are also distortions in the structure of spending, with virtually the entire recurrent education budget allocated for salaries, leaving few resources for other qualitative inputs such as teacher training. Early childhood and pre-primary education and literacy programmes in particular have been severely under-funded, each receiving less than 0.1 per cent of the education budget in 2014.100

99 For example Burkina Faso, Burundi, Côte d’Ivoire, Ethiopia, Lesotho, Mali, Mozambique, Namibia, Rwanda and Tanzania all allocate at least 20 per cent of the state budget to education.
5.8 Lowering demand-side barriers\textsuperscript{601} to education

School attendance depends both on the supply of education (schools, teachers and other inputs), and on demand for education, which is influenced by costs to households, perceptions of the benefits of education and socio-cultural factors. The leading reason given by parents and guardians when asked why their children aged 6-17 did not attend school was ‘distance to school’ (36 per cent) – a supply-side factor related to school infrastructure and the lack of government-funded school transport (IBEP 2008-2009). The second most common reason given for non-attendance was ‘dislike of studying’ (30 per cent) which might reflect cultural attitudes as well as problems in the quality of education services, and the third reason cited was lack of learning materials (9 per cent). ‘Dislike of studying’ might also reflect the perception that studying has low returns in terms of future employment and earnings. Although not explicitly mentioned, it is possible that security and hygiene – including the lack of water and toilets in many schools – might be a particular concern for girls.

**Figure 5.7 Reasons given by parents for children not attending or having never attended school (%), 2008-2009**

<table>
<thead>
<tr>
<th>Reason for never having attended school (children aged 6-9)</th>
<th>Work or domestic duties</th>
<th>Dislike studying</th>
<th>No schools, school places or teachers, or school far...</th>
<th>Very expensive</th>
<th>Not old enough</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2%</td>
<td>7%</td>
<td>23%</td>
<td>12%</td>
<td>40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for not attending school in current school year (children aged 6-17)</th>
<th>Cost</th>
<th>Pregnancy</th>
<th>Domestic duties or work</th>
<th>Lack of learning materials</th>
<th>School far away</th>
<th>Dislike studying</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3%</td>
<td>5%</td>
<td>11%</td>
<td>9%</td>
<td>36%</td>
<td>30%</td>
</tr>
</tbody>
</table>


The perception that children are ‘not old enough’ is the main reason given for late enrolment of children in primary school. Late entry into school along with subsequent repetition, leads to many children being over-age in primary school, with negative implications for later retention as primary school children reaching adolescence are far more likely to drop out of school due to the competition with work or, pregnancy and/or marriage in the case of girls. The IBEP 2008-2009 reported that 40 per cent of 6-9 year olds who had never been to school were considered too young. For children who had never attended school, supply-side factors such as lack of schools, lack of teachers or the distance to school are the second most important barriers to enrolment (23 per cent), followed by cost (12 per cent). In the younger age group, work or domestic duties were much less likely to keep children from attending school (2 per cent).

There is a need to increase the number of schools that provide meals to pupils as a measure to incentivize and facilitate school attendance, particularly among younger children.

\textsuperscript{601} ‘Demand side barriers’ refers to factors related to the users of services (in this case education) that constrain or hamper access to the services. Demand side barriers include those depending on the knowledge, behaviours and practices of the users of the services, e.g. lack of knowledge of the availability of the service, misconceptions about the usefulness of the services, etc. Demand side barriers can also result from the users’ lack of sufficient financial means to cover the direct and indirect costs required for accessing the services (e.g. transportation costs, service fees, etc).
evidence indicates that school feeding is a strong pull factor that helps to raise school attendance (see for example Adelman et al 2008). In Angola poverty and food insecurity mean that many children are not fed at home in the morning and go to school hungry (see Section 4.3). A school feeding programme was first proposed by MED in 2001 and scaled up nationally in 2007, however available information indicates that the programme only covers a small number of schools. Where the programme exists, it is delivered by private companies contracted by the provincial governments.

Primary education is officially free, but households must pay various associated costs out-of-pocket to send their children to school. In accordance with Article 7 of the Education Basic Law of 2001, public primary schools may not charge fees, however due to the lack of systematic budgetary transfers and inadequate material support as discussed above, some schools levy informal charges or contributions, usually through school committees (CPEEs), to meet their running or capital costs. There is not yet a clear set of regulations on the implementation of free primary education backed up by inspection to monitor compliance. Following a recent preparatory study, plans are in place for such regulations to be drafted along with procedures for compensatory transfers to schools (MED & UNICEF, 2012). Families also have to buy school uniforms and in some cases, textbooks and basic school materials such as notebooks and pens.

As children become adolescents, work and pregnancy account for an increasing number of dropouts. Opportunity costs – whereby school attendance competes with work in and outside the home – overshadow the direct costs of school, particularly among older children. Overall, work and domestic duties are cited by 11 per cent of parents as the reason their children aged 6-17 years are out of school. This proportion rises to 17 per cent among 15-17 years old. Pregnancy likewise becomes an increasingly important factor in adolescence cited as the reason children dropped out of school by 2.6 per cent of parents of out-of-school children (boys and girls) aged 12-14, and 7.3 per cent for children aged 15-17. Among girls who no longer attend school, pregnancy was the reason for 15 per cent of drop-outs. As noted above, late entry into primary school and repetition of grades means that many children in primary school are already adolescents, and therefore at risk of dropping out for these reasons before they complete grade 6. While birth certificates are not required for entry into primary school, they are necessary for college entry exams and secondary school enrolment and not having a birth certificate may prove a barrier for many children, particularly in rural areas. At secondary level, the lack of schools or student places is by far the most important barrier to attendance. Direct costs also increase at the secondary level, as secondary education is not free.

Adjusting the school calendar to accommodate agricultural cycles could mitigate the opportunity costs of education for children in rural areas. The school calendar is set at the national level and adhered to throughout the country. However, the most intense period of agricultural activity coincides with the rainy season, which begins in October, shortly before the end of the school year. The need to work in the fields forces many students to drop out of school right before the end-of-year exams (UNICEF 2011a). In some areas, seasonal migration or initiation rites may also clash with the school calendar, which could adversely impact on school attendance. Adapting the school calendar to local economic and cultural realities could facilitate school attendance and achievement among affected children.

5.9 Summary of priority actions

Although access to basic education has improved dramatically since the end of the war, advances in education have not benefited all Angolans equally. Many children, especially in rural areas, do not have easy access to basic education. The main priorities for the coming years therefore relate to improving equitable access and quality as well as strengthening planning, financing, management and monitoring of schools.

102 It was not possible to obtain basic data on the implementation of the school feeding programme.
Improving equitable access to education will require the following actions:

1. **Increase funding to early childhood education (ECD)** including to ‘classes da iniciação’ to ensure that children are ready to learn and succeed when they start primary school. Increased funding should focus on building childhood centres closer to communities and building a communication strategy about the importance of early and timely entry into education for young children.

2. **Accelerate investment in school construction and maintenance at all levels of general education and in particular in secondary education.** Improve the geographic targeting of new infrastructure to increase access to schools in rural areas and reduce geographical disparities. It is also important to ensure that schools are built according to agreed safety and sanitation standards and to scale up the provision of clean water and sanitation in all schools.

3. **Continue providing technical assistance to strengthen second chance education, prioritising the following actions:** (1) Strengthen the coordination and implementation of the Programa da Alfabetização e Aceleração Escolar (PAAE); (2) Promote the use of ‘mobile projects’ for ethnic and migratory groups; (3) Adapt school calendars to seasonal labour demands or dry/wet seasons; and (4) Conduct planning for education in emergency situations.

4. **Adopt detailed regulations and enforce adherence to the principle of free primary education.** One comprehensive regulation (as opposed to a set of different regulations for finance, school feeding, delivery of books, transport, uniforms etc.) should govern the implementation of free education for all. Studies should be conducted on costs per student in secondary school to assess the possibility of extending free education to at least the first cycle of secondary level.

5. **Assess the effectiveness of the school feeding programme and identify a viable model to implement nationally as a measure to attract and retain children in school.** The school feeding programme must ensure that the most deprived areas of the country are reached and seek to strengthen community participation and promote the procurement of local food.

6. **Develop and enforce a policy framework promoting equal access for children with special needs.** Clear directives for implementation should include teacher training, the provision of special learning materials and improvements to the physical accessibility of classrooms. Equitable access to education for children with disabilities should be a significant focus in this framework. Provision of bilingual education in the early grades of primary school is also an important strategy to reach children who do not speak Portuguese as their mother tongue.

7. **Pilot measures to promote girls’ education at secondary school level, particularly in rural areas.**

8. **Establish and scale up ongoing community awareness activities to deliver messages about the value of education, the importance that children start school at the correct age, and promoting completion of school.**

9. **Increase efforts to make schools a safe and healthy environment for all children including girls and young women.** This includes actions to raise awareness on the issue of violence in school and piloting measures to ensure schools offer a child friendly and safe learning environment.

**Improvements to the quality of education should focus on the following actions:**

10. **Strengthen the management of INFQ to improve pre-service and in-service training for teachers,** with a focus on integrated pedagogy, lesson planning, child oriented teaching, teaching life-skills, and learners’ and teachers’ assessments at all levels (early childhood education, primary and secondary education).

11. **Increase funding for teacher retention and teacher training to help end the shift system thus increasing pupil-teacher-contact hours.** Increased contact hours can be achieved through (1) improving the deployment and motivation of teachers, (2) decision-making based on teacher demand and supply
12. Improve the production and distribution of learning materials, through stronger supply chain control, improved distribution, maintenance and storage. An assessment of the current distribution and utilisation system should be carried out to identify the best measures to strengthen supply chains of learning materials.

Strengthening planning, financing, management and monitoring of the education system will require the following actions:

13. Increase the overall share of education in public expenditure, so that expenditure per pupil at least matches that of other middle-income SADC countries.

14. Conduct an organisational assessment to identify the strengths and weaknesses of education administration at national, provincial and municipal levels. The assessment should aim to identify staffing gaps at the different directorates and repartitions according to priorities set in the National Development Plan for Education (Plano Nacional de Desenvolvimento da Educação, PNDE) for the period 2015-2025.

15. Initiate training and support for school directors and school committees in education leadership in areas such as planning for school improvement, financial management and monitoring of students’ and teachers’ performance. Support should enable the school inspectorate to pay regular visits to schools and advise/coach school directors and school committees on measures needed to improve the school performance.

16. Make further efforts to improve the education management information system and gradually include more information on learning outcomes and teacher performance in particular in the areas of literacy, mathematics, science and life skills.
CHILDREN AND WOMEN IN ANGOLA

SITUATION ANALYSIS

© UNICEF ANGOLA - 2015 - 002064/Germán Mélé
Chapter 6.
Protecting children from violence, abuse, exploitation, discrimination and social exclusion

All children are entitled to a protective environment where they can live free from violence, abuse and neglect. Children are by nature more vulnerable than adults and in greater need of protection, but some are especially vulnerable due to lack of a nurturing family environment, gender bias, disability, domestic violence, poverty, unemployment, or harmful traditional practices. These children face heightened risks of abuse and exploitation, as well as social exclusion and deprivation – particularly when they have lost the care and affection of one or both parents. Factors that affect a child’s vulnerability might be rooted in poverty and/or in socio-cultural values and behaviours. Section 6.1 describes the profile of risks and vulnerability for children in Angola. Section 6.2 assesses the extent to which Angola has put in place the systems and services needed to reduce vulnerability and prevent and respond to violations of protection rights of children. Section 6.3 identifies the main priorities for establishment of an effective child protection system.

6.1 Profile of vulnerability and risks

Children and especially those who are orphans experience heightened vulnerability to rights violations. The IBEP 2008-2009 provides the most recent data on orphanhood estimating that 9.5 per cent of children in Angola are orphans of one or both parents. Although there is no major difference in the proportion of orphans in urban and rural areas, orphanhood does show some association with household wealth. In the richest quintile, 6.7 per cent of children are orphans as compared to 12.8 per cent in the poorest quintile – likely an effect of the relationship between poverty and mortality. One per cent of children in Angola (0.9 per cent) have lost both their parents.

Orphans account for only a small proportion of the numerous children who are not living with their biological parents. The IBEP 2008-2009 estimated that 12 per cent of children do not live with either their father or mother, even though less than one in twelve of these children are double orphans. In fact, in over two thirds of these cases, both parents are alive. Overall, one third of children in Angola do not live with one or both of their parents (see circle in Figure 6.1). Of the 18 per cent of children living with their mothers only 13 per cent have living fathers (see Figure 6.1). According to the National Institute of Children (INAC), absent fathers frequently fail to provide materially for their children. There is a widespread practice of informal fostering, often but not always within extended families. In its most extreme forms, the separation of children from their parents involves deliberate abandonment or trafficking. Evidence from many countries shows that children deprived of the care of their own parents are at higher risk of abuse and deprivation. These children are less likely to be in school and to have their birth registered, and are more likely to be engaged in child labour.
Chapter 6. Protecting children

Children who are living completely outside a family environment, such as children in prison and children living on the street, are amongst the most vulnerable of all children. These children are deprived of the care and affection of adults in a family, and exposed to very high risks of violence, abuse and exploitation, as well as deprivations in access to education and health care. One of the main categories of violence reported to INAC involves children, often orphans, who are accused of witchcraft and for this reason, subjected to violence and abandonment (MINFAMU 2013). The trafficking of children, for exploitation as domestic maids, labourers or sex workers, is recognized as a problem but there is almost no information about the scale or nature of trafficking. Although children living completely outside a family environment are a relatively small population, their situation requires attention for the disproportionate risks they face.

Juvenile delinquency in Angola has been on the rise in recent years in both urban and rural areas, but with higher incidence in towns and surrounding suburbs. Growing rates of offences committed by adolescents and the involvement of children by adults in criminal activities reflect the ongoing challenge of re-establishing social stability following nearly 40 years of conflict. The war inflicted tremendous physical and emotional damage on the country, breaking down social and family structures and leaving many young people without support to mitigate their exposure to the various risks associated with growing up in context of high social inequality, high unemployment, forced migration, and poverty.

Disability is an additional vulnerability which raises the risks of deprivation and social exclusion for affected children. According to the QUIBB 2011, disabilities affect 3 per cent of the total population and 1.3 per cent of children, although it is likely these figures underestimate the true situation as they rely on self-reporting. The main causes of disability in children are genetic factors, complications during pregnancy and childbirth, childhood diseases and accidents including injury from landmines. The QUIBB estimated that 13 per cent of households have at least one member with a disability. Children with disabilities can experience higher risk of violence due to difficulty defending or expressing oneself. There is a real risk that children with disabilities may not be registered at birth due to feelings of shame or social stigma which further limits their access to regular schools, social welfare services and benefits. Children with disabilities have little access to specialized services, are often kept in isolation within the home and risk abandonment, stigmatization and social exclusion (see Box 6.1). Children living in a household with a disabled adult may become caretakers at the expense of their own education and development.


Figure 6.1 Proportion of children living with both, one or neither of their parents, 2008-2009

Disability is an additional vulnerability which raises the risks of deprivation and social exclusion for affected children. According to the QUIBB 2011, disabilities affect 3 per cent of the total population and 1.3 per cent of children, although it is likely these figures underestimate the true situation as they rely on self-reporting. The main causes of disability in children are genetic factors, complications during pregnancy and childbirth, childhood diseases and accidents including injury from landmines. The QUIBB estimated that 13 per cent of households have at least one member with a disability. Children with disabilities can experience higher risk of violence due to difficulty defending or expressing oneself. There is a real risk that children with disabilities may not be registered at birth due to feelings of shame or social stigma which further limits their access to regular schools, social welfare services and benefits. Children with disabilities have little access to specialized services, are often kept in isolation within the home and risk abandonment, stigmatization and social exclusion (see Box 6.1). Children living in a household with a disabled adult may become caretakers at the expense of their own education and development.

The QUIBB 2011 did not use specialized methods for detection of disabilities.
Due to low rates of birth registration, large numbers of Angolan children have no proof of their legal identity and risk being unable to access their citizenship rights including essential social services. Less than one third (31 per cent) of children under 5 years of age in Angola were registered at birth. The rate of registration is slightly higher in urban areas (33 per cent) than in rural areas, and is particularly sensitive to household wealth, with registration increasing from 27 per cent in the poorest two quintiles to 43 per cent in the richest quintile (see Figure 6.4). In some provinces, such as Kwanza Sul, Malanje and Bié, less than 20 per cent of births are registered.

Although primary schools do not insist on presentation of a birth certificate for enrolment in the lowest grades, from grade 4 onwards a birth certificate is usually requested and it is a formal requirement to enter secondary school. Children whose birth was not registered have lower school attendance rates than children with birth certificates. Furthermore, verification of identity and age by means of birth certificates or ID cards (available from the age of 5) makes it easier for social workers and other actors to protect children from rights violations such as underage marriage and child labour. It also facilitates observance of children’s special protection rights in the judicial and penal systems in accordance with the law (see Section 6.2) and in the case of separated children, helps social workers to find parents or relatives.

**Figure 6.2 Birth registration among children under 5 by residence and wealth quintile (%) registered at birth, 2008-2009**

<table>
<thead>
<tr>
<th>% of children registered</th>
<th>National</th>
<th>Urban</th>
<th>Rural</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
</tr>
</thead>
<tbody>
<tr>
<td>31%</td>
<td>33%</td>
<td>29%</td>
<td>27%</td>
<td>27%</td>
<td>32%</td>
<td>31%</td>
<td>43%</td>
<td></td>
</tr>
</tbody>
</table>


**Box 6.1 Vulnerability and protection for children with disabilities**

Children with disabilities are amongst the most vulnerable members of society, having to cope not only with diminished functional capacities but also with stigma and discrimination. Inadequate provision and accessibility of specialized services combined with disadvantage and discrimination puts these children at high risk of social exclusion. Persons with disabilities have historically had much lower access to education than the general population (see Figure 6.3); among the population aged 6 and above, 32 per cent of those with disabilities had never been to school compared to 20 per cent of the general population. Almost half of females with disabilities (45 per cent) have never been to school.

**Figure 6.3 Proportion of the population with disabilities and of the general population aged six and above that never went to school, 2008/09 (%)**

<table>
<thead>
<tr>
<th>% never want to go to school</th>
<th>Population with disabilities aged ≥ 6 years</th>
<th>General population aged ≥ 6 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>29%</td>
<td>13%</td>
</tr>
<tr>
<td>Female</td>
<td>32%</td>
<td>15%</td>
</tr>
<tr>
<td>Male</td>
<td>45%</td>
<td>22%</td>
</tr>
<tr>
<td>Rural</td>
<td>33%</td>
<td>39%</td>
</tr>
<tr>
<td>Urban</td>
<td>33%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Source: IBEP 2008/09.
Policy framework
The Government has adopted an extensive package of legislation, policy and planning instruments to defend the rights of persons with disabilities and extend their access to services. These include:

- Law on Persons with Disabilities (Law no 21/12).
- Presidential decrees no 237/11 and 238/11 laying out policy and strategy for people with disabilities, providing a set of normative guidelines for their protection, promotion and social integration.
- Specific legislation on special education (Decree no 56/79), disabled war veterans (decrees no 85/81 and 86/81) and a disability pension (Law no 6/98).
- Law on Social Protection (Law no 7/04) defines the foundations and objectives of basic social care, specifically extending protection to people with disabilities and children and adolescents with special needs or at risk.
- Decree no 105/12 establishing the National Council on Persons with Disabilities (CNAPED).
- Decree no 207/14, approving the Social Intervention Strategy for Inclusion of Children with Disabilities.


The policy framework for people with disabilities in Angola is overwhelmingly focused on adults and even Law no 25/12 on the Protection and Integral Development of the Child, has little specific content on children with disabilities. There is a need to introduce specific legislation for children with disabilities to provide a broad multi-disciplinary framework for their protection.

Programmes
A total of 89,438 persons with disabilities (including 28,456 children) were registered in the Provincial Directorates of Social Assistance and Reintegration as of March 2012. Excluding special education, a similar number (87,769) received some kind of assistance between January 2011 and June 2013, mainly in the form of mobility and other technical aids, support for training, employment and revenue-generating activities and physical rehabilitation services (MINARS 2013).

It is estimated that only 15 per cent of the population with disabilities including 20 per cent of children with disabilities are registered with the provincial social assistance offices and/or received assistance from the State. Given that surveys are likely to underreport the prevalence of disabilities, these proportions are likely overestimates and programmes supporting adults and children with disabilities need to be dramatically scaled up to improve coverage.

Health
There is a need to improve access to physical rehabilitation services while developing other specialised services. Angola has 11 orthopaedic and physical rehabilitation centres, of which three are in the capital. Access to rehabilitation services outside the capital is difficult, especially for those living in the rural areas.

- The Assistance Programme for Persons with Disabilities, approved by presidential decree no 151/12, aims to improve coverage, in particular by building capacity to produce prostheses (MINARS 2013).
- The National Health Development Plan (PNDS) addresses the need to expand coverage of physical rehabilitation services, while developing new services for persons with sensory, intellectual and multiple deficiencies.

Education
Nationally there are 14 special education schools for children with severe disabilities and some teachers receive training to meet the needs of children with disabilities in integrated classrooms. Data from the Ministry of Education indicate that there was a fivefold increase in the number of children enrolled in special education (including integrated classes) between 2001 and 2011 when programmes reached 23,193 children. However, special education still reaches only about one quarter of the more than 90,000 school-age children with disabilities.

Social support
Angola has not yet implemented a disability subsidy for persons with disabilities although this was legislated 16 years ago. Law no 6/98 envisaged a state subsidy for persons with a permanent incapacity to work and no other social security benefits or means of support. This subsidy would provide a valuable compensatory mechanism (including for children with disabilities), but it was never implemented for lack of the necessary regulations.
Poor children and those in rural areas of Angola are at high risk of involvement in some form of child labour. The IEPE 2008-2009 found that one in five children aged between 5 and 14 years was engaged in child labour. Children living in rural areas were far more likely to work (32 per cent) than those living in urban settings (11 per cent). Child labour is also associated with poverty: children in the poorest quintile were more than twice as likely to be involved in child labour (26 per cent) than children in the richest quintile (11 per cent). The prevalence of child labour is particularly high in some provinces, such as Cunene (45 per cent) and Zaire (55 per cent), while it is lowest in Luanda (9 per cent). Some types of work, such as commercial sex work, expose children to very high risk of abuse and infection with HIV or other sexually transmitted diseases, however there is very little information on the prevalence of sex work among children.

Angolan labour law provides some degree of protection to children, however limited law enforcement undermines its efficacy. Law no. 02/00 allows for the employment of children aged 14-17 only when sanctioned by parents or guardians and prohibits employment in activities prejudicial to children’s development. However, there is an urgent need to develop a clear regulatory framework defining enforcement and accountability mechanisms, as well as to establish formal protocols for referral.

Domestic violence and abuse pose significant threats to women and children and incidents are widely underreported. The INCAPSIDA 2010 found that 29 per cent of women in marital union aged 15-49 reported being victims of physical or sexual violence in the previous 12 months. The proportion of women who experienced domestic violence increased with age from 20 per cent among women aged 15-19 to 30 per cent among women aged 20-24 and 32 per cent among women aged 25-49. Male violence against spouses and the use of corporal punishment to ‘educate’ and discipline children appears to be common and accepted in some local cultures. Cultural acceptance of domestic violence presents a major barrier to law enforcement, underpinning fear and a reluctance to report cases. Acts of sexual violence are very rarely reported to the police or brought to court – often being considered personal matters that are best addressed within the family or by mediation between families. The vulnerability of girls and women to domestic abuse is heightened by their economic dependence on male partners who are often several years older.

Children and especially girls face risks associated with underage marriage and early pregnancy. Among females aged 12-19 who are married or in marital union, 11.9 per cent have husbands who are at least 10 years older, and among girls aged 12-14, the proportion with husbands at least 10 years older rises to 41 per cent (IEPE 2008-2009). The proportion of women with husbands at least 10 years older is higher in the richest quintile and in urban areas, suggesting that wealthier urban men are more likely to marry girls much younger than themselves. The proportion of girls marrying below the minimum age of 18 established in Angolan law (with some qualifications under the Civil Code) is relatively low, compared with other Sub-Saharan African countries. Nonetheless, 0.4 per cent of all children and close to 1 per cent of girls aged 12-14 have been married. Among adolescents aged 15-19, one in five girls are married, and many more have been pregnant at least once: 7 per cent of girls aged 12-14 and 55 per cent of girls aged 15-19 have already delivered their first baby, with little difference between wealth groups, areas of residence or education levels (IEPE 2008-2009). Early marriage and above all early pregnancy negatively affect girls’ opportunities in life, often leading them to stop their education and limiting prospects for future employment. Girls who have children before they are fully mature also face higher risks of maternal and neonatal mortality and debilitating conditions such as obstetric fistula. As noted in Chapter 5, for 15 per cent of girls aged 15-17 who are out of school, pregnancy was cited as the reason they left school.

---

104 Child labour is defined as the “Percentage of children aged 5 to 14 years of age involved in child labour activities at the moment of the survey. A child is considered to be involved in child labour activities under the following classification: (a) children 5 to 11 years of age that during the week preceding the survey did at least one hour of economic activity or at least 28 hours of domestic work, and (b) children 12 to 14 years of age that during the week preceding the survey did at least 14 hours of economic activity or at least 42 hours of economic activity and domestic work combined” (UNICEF).

105 Data on child labour was also collected in the QUIBB 2011. However such data refers to the age group 10-17 years. QUIBB data show that child labour affects 30 per cent of children in this age group. While there is almost no difference between males and females, the QUIBB found that a much higher proportion of children aged 10-17 were involved in child labour in rural areas (57 per cent) than in urban areas (9 per cent).

106 For all adolescents (girls and boys) aged 15-19, the proportion in marital union is 9.7 per cent.
Severe droughts that cyclically affect Angola exacerbate existing protection risks and weaken community-based child protection mechanisms. A Child Protection Rapid Assessment conducted in 2012 in Kwanza Sul province by INAC with the support of UNICEF, showed that children are more exposed to psychological and physical violence due to increasing tension within households facing limited access to food and income. Girls are especially vulnerable to sexual violence, especially when they have to walk long distances to fetch water for the household. Field visits and consultations with development partners in Cunene and Huíla provinces during 2013 and 2014 revealed that as consequence of the drought, children were engaging in labour and migrating with livestock. Children were also more vulnerable to neglect by adults and young girls were likely to be left at home alone to take care younger siblings while parents travelled long distances to neighbouring markets or croplands.

6.2 Building an integrated child protection system of preventive and responsive services

To effectively mitigate the threats of violence, abuse, exploitation, neglect, discrimination and exclusion requires a protective system of policies and laws, regulations, formal and informal services and family practices that minimize children’s exposure to risks by addressing the social and economic drivers of vulnerability and strengthen children’s own resilience. A strong protective environment not only minimizes vulnerability and risks, but also establishes a positive context for the physical, intellectual and emotional development of children, thereby helping to ensure that all children contribute to and benefit from broader economic and social development.

The development of an effective policy framework for child protection is complementary to the process of building a strong social protection system, with both preventive and responsive components. The wider role of social protection in protecting the rights of children, developing their capacity, building resilience and promoting poverty reduction, equity and social cohesion is discussed in Chapter 7. This section focuses specifically on management of risks and response to violations of children’s protection rights. Effective child protection systems reduce the risks that lead to abuses through preventive measures that raise awareness and enable early detection of risks, and empower communities, families and children to mitigate threats. Child protection systems also need to be able to provide an effective response when risks are acute or violations have occurred, and to promote remedy, recovery, resilience and self-esteem in those who have suffered abuses, including reintegration into families and broader social inclusion.

The legal and policy framework for child protection is well established. Chapter 2 discussed the advances achieved through the enactment of Law no 25/12 (the law on the protection and integral development of the child), as well as legislation providing protection for children in specific areas. Law 25/12 gave legal endorsement to the 11 Commitments for Children, adopted by the Government in 2007 as an overarching policy framework for the survival, development and protection of children. Four of the 11 commitments specifically concern protection rights: Commitment 3 addresses birth registration, Commitment 6 addresses juvenile justice, Commitment 8 addresses violence against children and Commitment 9 targets social protection and family competencies. Other policy documents relevant to child protection include the National Strategy for the Prevention of and Fight against Violence against Children, led by INAC and the National Plan to fight Domestic Violence. Ongoing legal reforms should be seized as opportunities to further harmonize national legislation with international standards. In particular, revision of the Criminal Code should address the age of criminal responsibility as well as other protection issues.

While firmly established, the policy framework for child protection lacks operational clarity and implementation is lagging. The legal framework for child protection clearly articulates the general

107 Including: the Family Code (Law no 1/88) regulating marriage, adoption, foster care, parental responsibilities etc., as well as the Criminal Code, the Labour Law (Law no 2/00), the Basic Law on Social Protection (Law no 7/04), the Law and Regulation on Domestic Violence (Law no 25/11) addressing all types of violence committed at home, in educational facilities, hospitals, institutions, and the Law on Juvenile Justice creating the Children’s Court and establishing the system for judicial protection of children in conflict with the law as well those at risk.
principles and components of protection in different fields; however the content and procedures of specific programmes, along with the institutional responsibilities and financing mechanisms for operationalisation still need to be defined. The impact of the legal framework on protection of Angolan children will be very limited until operational details are defined and implemented.

Building a strong protective environment for children involves everyone: the state, the private sector, civil society organizations, the churches, the media, communities, families, and children themselves. The State is bound both by its constitutional obligation to protect children and commitments to do so under international law. Families – and especially parents and carers are the duty-bearers most directly responsible for the day-to-day protection and care of their children.

Due to the diversity and complexity of factors behind violations of children’s protection rights in Angola, many different sectors and institutions need to be involved. Violations of children’s rights often need to be addressed simultaneously by several actors, or require the referral of families and individuals to complementary (specialized) services provided by different institutions. Social care services, overseen by the Ministry of Social Assistance and Reintegration (MINARS) in Angola, are at the heart of a multi-disciplinary system. Other crucial actors include law enforcement, justice, education, health and labour sectors, as well as the National Children’s Institute (INAC) and the Ministry of the Family and Women’s Promotion (MINFAMU). Due to the process of administrative de-concentration and decentralization under way in Angola, provincial governments and municipal administrations have a particularly important role to play in the provision of protective services. Given their multisectoral nature, sub-national administrative structures are in principle well placed to facilitate cross-sectoral coordination and the development of effective referral mechanisms. At the central level, the National Children’s Council (CNAC) is mandated to play a coordinating role, as described in Chapter 2.

Informal child protection networks at community level should be empowered as pillars of a deep-reaching and integrated response. The effectiveness of these networks could be improved by ensuring that they are recognized and managed by community members rather than by external organizations. Community protection networks should be equipped directly with training and financial resources, as well as appropriate guidelines to regulate their interaction with social services through referral systems.

Child protection requires enforcement of the law, establishment of clear accountability mechanisms, case management and operational policies and programmes. In practice, the child protection system is weak and under-resourced in terms of both personnel and financing, and suffers from poor coordination across sectors and between the State and civil society actors. A major area of concern is the virtual absence of front-line social care and protection services at local or community level, especially outside Luanda and the provincial capitals. Further, there is no functional system of integrated case management and a lack of well-defined procedures and mechanisms for referral to specialized and complementary services. Other major weaknesses include access barriers to civil registration and inertia slowing the establishment an effective justice system for children that is consistent with international norms and the principles.

As in other sectors, data and information systems are critical in monitoring and planning service provision for child protection and along with budgeting for child protection, these areas need substantial strengthening. There is not yet an integrated management information system on child protection with agreed indicators and procedures for data collection and management. The CNAC has proposed a Sistema de Indicadores para a Criança Angolana (SICA) or Angolan Child Indicator System as a means of implementing its ambition to become a ‘national observatory’ on child rights. In practice, this overarching indicator system would have to build on effective management information systems within individual sectors (social assistance, education, justice, law enforcement, etc.) that are currently lacking. Further, there is no functional vital statistics system operating in the country, and despite the progress made by INE in some provinces, health and civil registration data do not effectively communicate. The lack of proper costing of interventions is another major weakness, as it results in the adoption of unrealistic plans and strategies that are not backed up by adequate budget allocations. These weaknesses in information, planning and budgeting pose significant constraints to implementation of child protection policies.
Chapter 6. Protecting children

6.2.1 Social care services

Social care services make up the branch of social protection that provide preventive and responsive services to address violence, abuse, exploitation, discrimination and social exclusion, including for children. Social care services are part of ‘basic social protection’, as defined by the Basic Law on Social Protection (Law no 7/04). The social protection system is discussed more fully in Chapter 7.

In Angola, social assistance including social care services, has evolved from a focus on humanitarian and reintegration assistance in the immediate post-war period to have a broader emphasis on the rights of vulnerable families and individuals, including in particular persons with disabilities, families affected by HIV and AIDS, orphans and other vulnerable children, destitute and isolated elderly persons and victims of natural disasters.

At the central level, formal social care services fall under the oversight of MINARS which is responsible for national policy, the setting of norms and the provision of guidance for the implementation of programmes at sub-national levels. The activities of MINARS are organized under five programmes, each comprising several projects:

- The Social Support Programme is an in-kind social transfer programme that distributes food and non-food assistance to vulnerable households (see Chapter 7);
- The Employment and Income Generation Programme, provides kits and training to help small numbers of vulnerable individuals to begin micro-enterprises;
- The Institutionalization Prevention Programme seeks to provide alternatives to placing children in homes and orphanages, notably through the foster mother scheme for abandoned young children (mães tutelares), the provision of milk substitutes and complementary foods (leite e papa) to mothers unable to breastfeed, and the promotion of alternatives to the incarceration of children in conflict with the law;
- The Programme to Assist the Elderly supports destitute old people without family support;
- The Institutional Capacity Building Programme provides training to social workers and other personnel in the protection sector.

Government-run social care services for children are presently small-scale, underfunded, and poorly linked to other sectors. Services are mostly concentrated in Luanda and some of the provincial capitals and overall the coverage of most services is very low. For example, in 2011 the Mães tutelares scheme supported the fostering of only 238 children under 3 years of age. Social care services are almost entirely absent in most rural areas, where child protection concerns are sometimes addressed on an informal and non-systematic basis through community structures such as the church, NGOs, traditional authorities (sobas) and other local leaders. Community structures taking on social care and protection do not always have adequate training, financial resources, recognition and support from local administrations to do so.

The lack of a system of integrated social care services at local level is a major challenge for effective protection of children. A network of integrated, multi-functional social care structures staffed by social workers is needed at community level to provide the preventive activities and response services for families, children and other at-risk groups. No such structures currently exist in Angola and the career of social worker is not even recognised in the official personnel structure of municípios and comunas. The few trained social workers in the system are concentrated in the provincial capitals and above all in Luanda, where the number of qualified personnel far surpasses that of all the other provinces.

Provincial governments and municipal administrations responsible for the delivery of services must give far greater priority and resources to social action. Although the Provincial Directorates of Social Assistance and Reintegration (DPARS) should follow technical guidance from the central ministry, they are administratively part of the provincial governments. This dual system continues down to the municipal level, where social assistance activities are carried out under the guidance of the DPARS at provincial level while staff (‘técnicos

108 Beyond MINARS, other ministries also run social care services. Noteworthy among them is the Ministry of the Family and Women (MINFAMU) which supports a programme for the strengthening of family competencies and the provision of assistance to the victims of domestic violence.
para a área social) are part of the municipal administration and report to the municipal administrator. With the exception of the major capitals, INAC is not represented in most municipalities. In some areas, there are also specialized social service units, such as the CIC/CEC for early childhood education (see Chapter 5), homes for the elderly, orphanages and institutions providing services for persons with disabilities. As in the other sectors, administrative deconcentration through horizontally structured provincial governments and municipal administrations (rather than through vertically structured line ministries) means that the degree of priority given to social action at local level depends to a large extent on the individual interest of provincial governors and the allocation of provincial budget resources. There are no budget lines for social action at the municipal level.

The draft National Social Assistance Policy proposes the establishment of integrated social action centres (CASI) to fill the gap in frontline services beginning at municipal level. CASI would be staffed by social workers, requiring substantial investment in their training, an adjustment in the official staffing or quadro de pessoal at municipal level and the deployment of social workers to municípios across the country to provide a core package of services. Appropriate funding arrangements would also have to be set up, preferably by designating the CASI as budget units and allocating adequate budgetary resources to them to carry out their functions without dependence on provincial allocations.

The draft policy indicates that CASI would carry out a mix of preventive and responsive functions and engage in social communication activities, to raise community awareness of risks and change harmful practices such as child marriage. CASI would also carry out preventive work within families through counselling to reduce the likelihood and severity of threats such as family break-up, domestic violence and abuse or neglect of children. The CASI would also intervene in the event of actual abuses, by providing support for victims and referring them to specialized services. Finally, the CASI would help facilitate access to basic services such as birth registration, education, health services and social assistance programmes by families and children in situations of social marginalization and exclusion.

Integrated case management requires strong inter-institutional links and the establishment of effective referral mechanisms. It is vital that child protection issues are not isolated within vertical programmes but rather integrated across sectors and institutions with relevant mandates and competencies. At the local level, the CASI would provide a framework for integrated case management, with referral to specialized services as required. For example, referrals might connect women and children who are victims of violence to temporary refuges, health services, and police and legal services where relevant.

The CASI should work closely with community-based structures recognised in the children’s law (Law no 25/11) as the cornerstone of a child protection system that will provide “quality services to children based on established standards and norms”. Child protection networks have already been established in some areas, composed of local leaders and volunteers such as teachers, sobas (traditional leaders), priests and, in many cases, government officials and/or NGO workers. Where functional, these networks are helping to identify and respond to violations of children’s rights, reduce harmful practices and transform community attitudes and behaviours.

6.2.2 Birth registration

Improving access to the civil registration system is crucial for achieving the goal of universal birth registration, set in the Government’s National Development Plan. Coverage of birth registration if low and only 31 per cent of children under-5 have a birth certificate. This is due in large extent to the weakness of registration services and to social standards and practices which constrain demand for registration. The main reasons cited by mothers for non-registration of their children are cost and distance, accounting respectively for 33 per cent and 16 per cent of non-registered children under 5 (IBEP 2008-2009). These barriers are particularly important in the rural areas and for children in poorer households (see Figure 6.4). It is therefore critical to bring birth registration services closer to the rural population and to cut the direct and indirect costs of accessing these services. The third most important reason for non-registration of children is the expiry of parents’ ID documents cited by 8 per cent of mothers surveyed. It is therefore also important to facilitate access to renewal services for ID cards. By contrast, very few mothers did not register their children at birth because they felt it was not important (3.5 per cent), were not aware that births should be registered (1.7 per cent) or did not know where to register births (4.5 per cent) (IBEP 2008-2009).
The Government has recognized the need for additional effort and has recently adopted several measures to increase coverage of birth registration. Recent measures include the abolition of birth registration fees for children under 5\textsuperscript{109}, an exemption of payment of registration fees for all Angolan citizens for a period of three years until 2016\textsuperscript{110}, and an exemption from payment of fees for first-time applications for Civil Registration and Identity Card\textsuperscript{111}. Furthermore, in line with recommendations from the 28th session of the Committee on the Rights of the Child, the Government launched a project for mass expansion of Birth Registration (Massificação) which targets the registration of 8 million citizens by 2017.

While large-scale campaigns will progressively clear the backlog of unregistered children\textsuperscript{112}, a strong focus should be maintained on building a routine system that is sustainable in the long term. Sustainability of the registration system in Angola will depend on wider availability of routine services, the availability of trained personnel in sufficient number and the establishment and implementation of appropriate procedures. The importance and urgency of investment in trained personnel emerged once again during a recent government diagnostic which found that the civil registration system would require a total of 2,810 civil servants, more than two and a half times the 1,064 currently in place.

The Ministry of Justice needs to continue to establish operational partnerships with other ministries to strengthen registration. For example, an important partnership was recently established with the Ministry of Health to provide registration services within maternity sections at health facilities. This partnership crucially allows for newborn children to be registered on site. Indeed increased cooperation with government structures from other sectors such as territorial administration, health, education and more could greatly increase points of access to registration services, particularly in underserved areas of the country.

Civil registration data remains incomplete and is thus not used as the source for vital statistics in Angola. There is a need to strengthen cooperation between the National Institute of Statistics, responsible for data collection and analysis, with the Ministry of Health and the Registration Offices. The Justice Sector Plan (2010-2025) includes the implementation of various projects and measures between 2014 and 2017 to strengthen registration, information and coordination, emphasizing the use of information technologies for storage, recording, dissemination and retrieval of information, thus improving communication and bringing greater dynamism to cooperation in civil registration.

\textsuperscript{109} Decree no 31/07.
\textsuperscript{110} Presidential order 80/2013.
\textsuperscript{111} Executive Decree No. 309/13 of 23 September.
\textsuperscript{112} The Ministry of Justice is planning to conduct a registration campaign using mobile teams to reach remote areas, as envisaged in the National Development Plan.
Regular availability of quality vital demographic data is crucial for the functioning of public administration and for the provision of services to citizens. In the absence of legal documents such as a birth certificate, individual rights and privileges are eroded, creating opportunities and legal loopholes for abuse and exploitation, especially affecting vulnerable populations such as children and women.

6.2.3 Justice for children

Access to justice is an inalienable right of all children; this includes access to quick, effective and fair measures to protect their rights, prevent or solve disputes and control abuse of power through transparent, affordable and accountable processes. Children entering in contact with the justice system should encounter specialised, age appropriate, speedy, and diligent processes that are adapted to the needs and rights of the child and respect the best interest principle.113

In Angola, national legislation related to access to justice for children is well developed through a number of provisions in the Constitution, the Juvenile Justice Act and the Children's Act. The legislative framework was upgraded in 2008, with the approval of the Joint Executive Decrees nos. 17/08 and 18/08, regulating social and educational measures of the Probation and Community Service Provisions respectively. The legislation establishes a model of juvenile criminal responsibility in accordance with the Convention on the Rights of the Child, which gives priority to non-custodial measures oriented towards the social reintegration of adolescents and their families. The current legislation is especially intended to prevent arbitrariness, often imposed on poor and disadvantaged children under the pretext of crime prevention. It aims to strengthen the legal system in such a way that young people can only be held responsible in compliance with the constitutional guarantees of due process, which includes their right to liberty, the presumption of innocence, and justice.

Rehabilitation, diversion114 and other alternative mechanisms involving families, communities and victims with the support of social workers and the judicial system, is a safer and more effective approach than punitive measures for youth, particularly incarceration. This is the stated policy of the Government, which formally aligned the legal framework for juvenile justice with international norms established in the Convention on the Rights of the Child and the UN Minimum Rules on the Administration of Juvenile Justice (the Beijing Rules) through the Law on Juvenile Justice (Law no 9/96).

Adolescents in conflict with the law face high risk of abuse, especially if they are detained with adults. They are also likely to be deprived of their rights to education, health and contact with family. These conditions compounded by stigmatization provide poor prospects for social reintegration and for leading a productive life in adulthood.

In Angola, there is a need for more rapid progress in the implementation of the Law on Juvenile Justice. Only one of the eighteen provinces – Luanda – has a specific court for children. In all other provinces, children charged with criminal offences are judged in provincial courts. There is evidence that some adolescents aged 16 years or older are sentenced to prison and often incarcerated in regular prisons with adults. A study in Huila found that while the justice system expedites juvenile cases and attempts to provide alternatives to incarceration such as probation, counselling and compulsory school attendance, these mechanisms are not effectively followed up due to the lack of clear institutional responsibilities, financial resources or trained personnel (Mozakio NGO 2013). Community service probation is only rarely used as an alternative for minors in conflict with the law. The study also found that outside the provincial capital and one municipal centre in Huila, the system does not operate due to the lack of resources.

112 Principle of the best interests of the child (Article 3 of the Convention on the Rights of the Child): The best interests of children must be the primary concern in making decisions that may affect them. All adults should do what is best for children. When adults make decisions, they should think about how their decisions will affect children. This particularly applies to budget, policy and law makers (UNICEF; accessed at http://www.unicef.org/crc/files/Guiding_Principles.pdf).

114 To divert or channel youth offenders out of the juvenile justice system.
The implementation of the national legal framework for juvenile justice requires practical solutions to improve coordination between the social and judicial sectors and among key ministries (Justice and Human Rights, Interior and Social Welfare). In addition, implementation must redress the lack of Tutelary Commissions and other subsidiary bodies to the Court for Minors in the provinces, the lack of separated detention centres for minors and the lack of regulations related to deprivation of liberty. Finally, there is a need to ensure that all magistrates, law enforcement agents, and other stakeholders have adequate knowledge and awareness of issues related to protection and child rights.

Some weaknesses in the implementation of measures to strengthen juvenile justice reflect problems afflicting the wider justice system. Access to justice by victims of violence or other crimes is extremely difficult, particularly for the poor and those living in the rural areas due to distance from courts, slow and costly procedures, low awareness of rights and the judicial process, and a lack of legal aid. The legal profession is overwhelmingly based in Luanda, which has 93 per cent of the country’s 656 lawyers (MINPLAN 2010). As a result of the inadequate number of prosecutors and magistrates, heavy bureaucratic procedures, and lack of computerization, the courts are overwhelmed leading to long delays in cases coming to trial. A legal aid system exists but access to it is particularly difficult for the poor due to distance and lack of information. In rural areas, an informal justice system operates through traditional authorities. Informal systems have the advantage of accessibility, making it possible to process minor offences using customary law and community mediation. However, there are also important contradictions between customary and statutory law, particularly with respect to the rights of women in marriage and divorce, child custody, property and inheritance.

6.3 Summary of priority actions

1. Create front-line units for the provision of preventive and responsive protection services. Without a network of social workers, it will be difficult to make progress in reducing child protection risks or in providing an adequate response to families and children in acute stress or who are victims of abuse. To establish functioning and effective front line units at local level, it will be necessary to:
   • Adopt legislation and regulations defining the purpose, functions and procedures of these structures. These regulations must specifically cover case management and referrals to other social services and protective bodies.
   • Introduce a cadre for social workers within the organizational structure of municipal administrations and train and deploy adequate numbers of social workers to staff front-line units.
   • Designate front-line units as budget units and ensure that adequate resources are provided based on costing of their activities.

2. Redouble efforts to strengthen civil registration and vital statistics systems and adopt multi-sector strategies to facilitate access to birth registration and identification procedures. More than 4 million Angolan children do not have a birth certificate. Lack of proof of legal identity hinders access to essential services and has implications for obtaining citizenship rights including the right to vote. The following emerge as priority actions:
   • Extend free access to birth registration to all children under 18.
   • Establish birth registration services in all health facilities.
   • Establish protocol with sectoral ministries as a way to increase the points of access to registration services, particularly in rural areas.
   • Complete the process of computerising the civil registration system to improve efficiency and security.
   • Ensure regular flow of vital statistics data between different ministries.
3. **Design and implement an appropriate model for justice for children in all provinces.** Children entering in contact with the justice system should encounter specialised, age-appropriate, speedy, diligent and integrated processes at the police and within the court system and social services. These processes must be adapted to their unique needs and rights and respect the best interest principle. Most children who enter in contact with the justice system have committed minor offences and many have done so for lack of parental support or supervision. Solutions to hold families and adolescents responsible for their actions and ensure social reintegration of young offenders into communities include psychosocial counselling, return to school, probation mechanisms and community service. Other children access the justice system in need of protection as victims or witnesses or as subjects of administrative proceedings such as adoption. The justice model should clearly designate different institutional responsibilities (involving the Ministry of Justice and Human Rights, Interior, the Office of the Attorney General, the Social Welfare in particular) and the procedures to be followed, and provide for the training of personnel and specific budget allocations for provincial courts to offer specialized protection for children in contact with the justice system.
Chapter 7. 
Addressing child poverty through Social protection

A strong social protection system is fundamental to reduce the vulnerability of the poor to social risks, build their resilience to livelihood shocks and improve human capital and productivity. As discussed in Chapter 3, millions of Angolans remain trapped in poverty. Poor families are generally larger than average in size and have a high dependency ratio due to having more children. They tend to be headed by persons who have low levels of education and are self-employed in small-scale agriculture or petty commerce, and therefore lack human capital, savings, and access to credit or physical assets that would enable them to escape from poverty.

Women and children living in poor families are particularly vulnerable. Analysis of equity in previous chapters has shown that poor women are exposed to higher reproductive health risks than wealthier women due to higher levels of fertility and early pregnancy and lower use of maternal health services. Women in poor households also shoulder a heavy load of productive duties within and outside the household, and are responsible for the care of children. Their children are more likely than children in wealthier households to suffer from under-nutrition, lack appropriate treatment when they are ill, experience delays in entering school, early school dropout and engage in child labour.

The effects of low participation in education, poor access to health care and under-nutrition during childhood echo through the adult years, diminishing wellbeing and productivity with serious long-term social and economic impacts. Low investment in human development during childhood creates a vicious cycle of poverty transmission from one generation to the next. It also constrains national development beyond the confines of enclave industries like oil and mining, and risks perpetuating inequalities that erode social stability and could eventually undermine post-conflict efforts to build a more cohesive and peaceful society.

The current social protection system in Angola is weak, but a draft National Social Assistance Policy (NSAP) (MINARS 2013) lays solid foundations for strengthening and scaling up the coverage of social protection. Historically, the social protection system has been limited to contributory social insurance schemes for the small minority of Angolans employed in the formal sector of the economy. This formal system has not reached the mass of the poor, who work overwhelmingly in small-scale family agriculture, petty commerce and other branches of the informal economy. At the other end of the spectrum, a few social assistance programmes, managed by the Ministry of Social Assistance and Reinsertion (MINARS), have provided ad hoc relief to some of the most vulnerable households. To date, there is no large national social protection programme that aims specifically to redistribute resources to the millions of Angolans who have not been able to benefit from the rapid economic growth of recent years. This may soon change however, with the draft NSAP currently awaiting formal adoption by the Government (see Section 7.3). Furthermore, the National Poverty Reduction Programme of the Ministry of Commerce recently launched a cash transfer programme providing cash to poor people to purchase a predefined sets of goods (see Section 7.2).

7.1 The role of cash transfers in building human capital and reducing poverty

At the height of the global economic crisis, in April 2009, the United Nations called on governments worldwide to establish a ‘social protection floor’ as a means of protecting the poor from the shockwaves of the crisis (UN 2009). The African Union, in the Declaration of Windhoek in October 2008, had previously urged African countries to set up stronger social protection systems as part of their broader efforts to reduce poverty (AU 2008).
Social protection aims to strengthen the capacity of families to manage risks and shocks and to reduce their long-term vulnerability. It is an umbrella term, encompassing many different types of programmes such as unemployment benefits, pensions and child grants, social insurance schemes, public works programmes and social care services. However, the core of social protection usually comprises three broad components, along with the body of protective legislation (see Figure 7.1):

- **Social insurance programmes**, which are contributory in nature, providing a mechanism for risk pooling to face the contingencies of life (unemployment, illness, disability, old age, etc.), and which tend to be limited to those in formal employment, greatly restricting their coverage in African countries with large informal sectors;
- **Social assistance programmes**, which provide non-contributory social transfers, usually tax-financed and benefiting the poor or specific vulnerable groups such as the disabled, the elderly or children, either in cash or in kind;
- **Social care services**, which are the ‘non-monetary’ branch of social protection, providing preventive and responsive services to address the risks of violence, abuse, exploitation, discrimination and social exclusion, including for children (as discussed in the previous chapter)\(^\text{115}\).

Social cash transfers in particular have become an instrument of choice to build resilience, promote redistribution, facilitate access to social services and reduce long-term poverty. Cash transfer programmes target beneficiaries using a variety of methods, including targeting by poverty level or focusing on specific categories of vulnerability, often defined by age (children and the elderly), disability or other individual or household characteristics, including poverty. Social cash transfers are implemented in many developing countries as well as in industrialized countries. The specific purpose of social transfers varies according to the nature of the transfer or target group, but they generally have multiple benefits:

- By transferring resources to households, cash transfer programmes help to guarantee a minimum level of consumption to meet basic human needs and to ensure human dignity.
- By making it easier for vulnerable households to meet the direct and indirect costs of accessing basic social services such as health care and schools, and to meet the nutritional requirements of their children, social cash transfers enable these households to build their human capital, improving the life-chances of their children and contributing to national economic growth and development.
- By increasing and stabilizing household resources, transfers enable the poorest households to begin small savings – often for the first time, to access micro-credit and to invest in improving their productivity, thereby helping to open a long-term pathway out of poverty and to make economic growth more inclusive and ‘pro-poor’.

\(^\text{115}\) Social care services were discussed in section 6.3.1.
• By injecting cash into the local economy, transfers help to stimulate local development in poor communities and regions through multiplier effects.

• During economic downturns, such as the global economic crisis in 2008-2009, the expansion of social transfers can act as a stabilizer of aggregate demand, helping to prevent a more severe decline in economic activity.

• By smoothing income and consumption in the event of adverse economic shocks or natural disasters such as droughts or floods, transfers help to build the resilience of vulnerable households, making it unnecessary for them to resort to adverse coping strategies such as the sale of livestock or other household productive assets or the withdrawal of children from school to engage in work.

• Finally, as a mechanism for redistribution as well as poverty reduction and the promotion of access to services, cash transfers help to reduce inequality and strengthen social cohesion. This can have a transformational effect on societies that are grappling with high levels of inequality and social exclusion, and can help to avoid the risk of such social tensions spilling over into internal conflict.

(DFID 2005 and World Bank 2012a & 2012b; The Transfer Project 2014)

Social transfers are generally paid in cash on a long-term regular basis, although temporary in-kind transfers may be justified in specific conditions. Cash transfers provide beneficiaries more flexibility to meet their different needs than in-kind transfers and are normally paid regularly over a long period of time in order to build the long-term capacity of beneficiaries or because in certain cases, such as for the elderly or the disabled, ‘graduation’ is not a realistic objective. In-kind transfers such as food assistance, also have the disadvantage of depressing local agro-food markets, thereby disincentivising local agricultural production. It is generally only when markets are not functioning well, due to conflict or other factors, or because of the specialized nature of the commodities concerned (for example, therapeutic foods for children suffering from acute under-nutrition, equipment for the disabled, or basic survival items after natural disasters), that there is a valuable and specific role for short-term in-kind transfers.

Box 7.1 Social transfers and ‘demand’ for basic social services

Access to health and education services reflects both the supply of these services and the demand for them. Access to education, for example, requires not only the existence of schools and teachers in the proximity of a household (the supply), but also the willingness of parents to send their children to school (the demand).

Demand is affected by direct and indirect costs, as well as sociocultural factors (such as early marriage and pregnancy leading girls to drop out of school) and problems with the quality of the social service (a supply-side problem) and the perceived ‘returns’ to households’ investments to access the service.

In the case of education, direct costs may include formal and informal school fees, and the purchase of books, school materials and uniforms. Indirect or opportunity costs are also important. Poor households may prefer a child to contribute to household income or resources, for example by assisting on the family farm or selling goods in the local market, rather than attending school.

By increasing household income, cash transfers can offset these direct and indirect costs and thereby increase the demand for basic services.

Conditional cash transfers (CCTs) aim to reinforce demand for basic social services by introducing explicit conditions, requiring the use of education and/or health services by beneficiaries’ children.

However, there is little evidence of additional impacts attributable to the conditions in CCTs over and above the income effect of the transfers themselves. Further, in the African context, there are concerns about the viability of CCTs in countries with serious supply-side constraints on the provision of social services, inadequate capacity in schools and health facilities to monitor beneficiaries’ fulfilment of conditions and a lack of social workers to follow up and resolve cases of non-compliance. There are also concerns that conditions may impose unnecessary transaction costs on beneficiaries and even risk excluding the most vulnerable.
Some programmes tie transfers to behavioural conditions on the part of recipients. These conditional cash transfers (CCTs) aim to build on the income effects of transfers by promoting positive behaviour change. Typically CCTs condition the receipt of transfers on the vaccination of young children, school attendance by school-age children and the participation of adults in informal educational sessions on hygiene, nutrition and child care practices. The use of conditions in cash transfers, which was pioneered on a large scale in Latin America, has however been the subject of considerable controversy (see Box 7.1).

The large cash transfer programmes established by middle-income countries in Southern Africa, such as South Africa’s Child Support Grant, (CSG), are all unconditional. The CSG is the single largest cash transfer programme in Africa, benefiting 11.5 million children in 2012 (see Box 7.2).

Other programmes tie transfers to participation in public works programmes (PWP). In such ‘workfare’ schemes, the transfer effectively becomes a wage, paid either in cash or in kind as in food-for-work programmes. The public works are intended to reduce poverty both in the short term through the provision of wage income and in the long term by improving the stock of community assets (rural feeder roads, irrigation systems, social infrastructure, etc.) or by strengthening environmental protection (for example through reforestation and anti-erosion works). In the rural areas of developing countries, PWP often aim specifically to reduce cyclical food insecurity that results from the seasonality of rain-fed food production and household incomes, by providing a safety net during the lean period before harvests. One of the largest programmes of this type in Africa is Ethiopia’s Productive Safety Nets Programme (PSNP), which benefits 7.6 million very poor rural-dwellers annually through tens of thousands of local public works projects.

Box 7.2 Social transfers in Africa

Although social protection systems in most of Africa have historically been weak, limited for the most part to contributory social security schemes for civil servants and other employees in the small formal sector, there has been a surge of interest in establishing and expanding cash transfers and public works programmes (PWP) in recent years, mainly as a means to accelerate poverty reduction. The African Union called for the development of social transfers by member-states in the Declaration of Windhoek in 2008.

A recent review has identified a total of 123 non-contributory social transfer programmes in Sub-Saharan Africa (World Bank, 2013). While some of these schemes were inspired by the success of the CCTs in Latin American countries such as Mexico and Brazil and have tried to emulate that model, other more home-grown programmes have eschewed the linking of transfers to behavioural conditions.

Several middle-income countries, especially in the SADC region, have established large and effective national cash transfer programmes targeted at vulnerable demographic groups, either as universal programmes or applying a poverty filter. South Africa has the most advanced programme in the region with a wide array of poverty-targeted but unconditional transfers, including a child support grant, an old age pension and a disability pension. The South African programme currently reaches 15.6 million people at a cost equivalent to 2.4 per cent of GDP. These grants and pensions have reduced the prevalence of poverty, increased school attendance, and improved nutrition, health and labour market participation. Most of the middle-income SADC countries have social pensions (for old age and disability) and Namibia also has a child grant.
There is substantial evidence of the positive effects of cash transfers on development, in particular with respect to poverty reduction, human capital development and the stimulation of economic development in poor communities. Studies in South Africa have shown that social transfers reduced monetary poverty and the Gini coefficient, improved nutrition in young children and increased entry at the correct age to primary school. There is also strong evidence from Kenya and Ethiopia of varied positive impacts of social transfers (see Table 7.2). Globally, the evidence from evaluations in many countries shows that social cash transfers have had significant impacts on household consumption, dietary diversity, school enrolment, access to health services, and early childhood development. There is also emerging evidence of the impact of social cash transfers on adolescent wellbeing and HIV prevention from South Africa and Kenya. Evidence of economic and productive impacts of social cash transfers comes from several countries including Kenya, Zimbabwe, Malawi, Ethiopia, Lesotho, Zambia and Ghana. Social cash transfers have also had statistically significant impacts on chronic under-nutrition in Colombia, Mexico, Nicaragua and South Africa. Several evaluations have also shown positive effects of cash transfers on school enrolment and attendance, especially in rural areas and in poorer households and – in countries with higher initial levels of primary school attendance – at the secondary level. Several of these studies have also shown declines in child labour.

Table 7.1 Major cash transfer programmes in Sub-Saharan Africa, 2012

<table>
<thead>
<tr>
<th>Country</th>
<th>Programme</th>
<th>Eligibility</th>
<th>Number of beneficiaries</th>
<th>Transfer amount ($/month)</th>
<th>Cost as % of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>Old age pension</td>
<td>Poor elderly 60+</td>
<td>2.9 million</td>
<td>124</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Disability pension</td>
<td>Poor with disabilities</td>
<td>1.2 million</td>
<td>124</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Child Support Grant</td>
<td>Poor children &lt;18</td>
<td>11.5 million</td>
<td>28</td>
<td>0.9</td>
</tr>
<tr>
<td>Botswana</td>
<td>Old age pension</td>
<td>Elderly 65+ (universal)</td>
<td>90,000</td>
<td>25</td>
<td>0.3</td>
</tr>
<tr>
<td>Cape Verde</td>
<td>Old age pension</td>
<td>Very poor elderly</td>
<td>21,000</td>
<td>60</td>
<td>0.8</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Productive Safety Nets Programme</td>
<td>Very poor rural households</td>
<td>7.6 million (2009)</td>
<td>...</td>
<td>1.2</td>
</tr>
<tr>
<td>Ghana</td>
<td>Livelihood Empowerment against Poverty (LEAP)</td>
<td>Very poor households with elderly, disabled or OVCs</td>
<td>68,000 households</td>
<td>7-13 (according to HH size)</td>
<td>...</td>
</tr>
<tr>
<td>Kenya</td>
<td>Cash Transfers for Orphans and Vulnerable Children (CT-OVC)</td>
<td>Very poor households with OVCs</td>
<td>230,000 OVCs</td>
<td>21 (average per HH)</td>
<td>...</td>
</tr>
<tr>
<td>Lesotho</td>
<td>Old age pension</td>
<td>Men 70+ and women 65+ (universal)</td>
<td>69,000</td>
<td>34</td>
<td>1.8</td>
</tr>
<tr>
<td>Mauritius</td>
<td>Old age pension</td>
<td>Elderly 60+ (universal)</td>
<td>162,000</td>
<td>103</td>
<td>2.2</td>
</tr>
<tr>
<td></td>
<td>Disability pension</td>
<td>Disabled (universal)</td>
<td>30,516</td>
<td>93</td>
<td>0.4</td>
</tr>
<tr>
<td>Mozambique</td>
<td>PSSB (Programa de Subsidio Social Básico)</td>
<td>Poor households with elderly, disabled or chronically ill</td>
<td>278,000 households</td>
<td>8-17 (according to HH size, 2013)</td>
<td>0.2</td>
</tr>
<tr>
<td>Namibia</td>
<td>Old age pension</td>
<td>Elderly 65+ (universal)</td>
<td>147,000</td>
<td>54</td>
<td>0.8</td>
</tr>
<tr>
<td></td>
<td>Disability pension</td>
<td></td>
<td>27,000</td>
<td>54</td>
<td>0.1</td>
</tr>
<tr>
<td></td>
<td>Child maintenance grant</td>
<td>Children &lt;18 in very poor households</td>
<td>86,000</td>
<td>10-20 per child</td>
<td></td>
</tr>
<tr>
<td>Swaziland</td>
<td>Old age pension</td>
<td>Elderly 60+ (universal)</td>
<td>60,000</td>
<td>26</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Sources: World Bank 2013; World Bank, World Development Indicators; HelpAge International; South African Social Security Agency; South African Department of Social Affairs; Statistics Mauritius; UNICEF; Namibia Economist.
### Table 7.2 Examples of the impacts of cash transfers and PWPs

<table>
<thead>
<tr>
<th>Country</th>
<th>Programme</th>
<th>Impacts (beneficiaries compared to non-beneficiaries)</th>
</tr>
</thead>
</table>
| South Africa     | Child Support Grant (CSG)                      | • Young child beneficiaries 5 cm taller  
• 8 percentage point increase in school enrolment by 6 year olds in grade 1  
• 1 point reduction in the Gini coefficient |
| Ethiopia         | Productive Safety Nets Programme (PSNP)        | • 19 per cent increase in calorie consumption  
• Construction of community assets  
• 28 per cent increase in livestock assets  
• Improvement in agricultural yields  
• Non-agricultural investments by beneficiaries  
• Increases in school enrolment and use of health services |
| Kenya            | Cash Transfers for Orphans and Vulnerable Children (CT-OVC) | • 13 percentage point decline in poverty incidence (at poverty line of $1/day)  
• 8 percentage point improvement in food consumption diversity index  
• 6 percentage point rise in secondary school enrolment by children aged 13-17  
• 3 percentage point decline in child labour |
| Mauritius        | Old age pension                                | • Without the social pension 30 per cent of households with elderly would be poor, compared with 6 per cent at present |
| Brazil           | Bolsa Familia (CCT for poor households)        | • 0.5 point decline in the Gini Coefficient  
• Improvements in vaccination and antenatal consultation rates  
• 11.5 percentage point rise in school enrolment by 5-15 year olds in 1st decile |
| Colombia         | Familias en Acción (CCT for poor households)   | • 6.9 percentage point decline in proportion of children under 2 with chronic under-nutrition  
• 11 percentage point decline in incidence of diarrhoea in children under 3 |
| Mexico           | Progresa/Oportunidades (CCT for poor households) | • 45 per cent decline in poverty severity  
• 7 per cent increase in calorie consumption  
• Increase in height of children under 5 (+15 cm in rural areas and +1.1 cm in urban areas)  
• School enrolment up 3.5-5.8 percentage points for boys and 7.2-9.3 percentage points for girls, and average length of schooling up by 0.66 years |
| Nicaragua        | Red de Protección Social (CCT for poor households) | • 5.5 percentage point decline in proportion of children with chronic under-nutrition  
• 13 percentage point increase in school enrolment and 20 percentage point increase in school attendance |


### 7.2 Social transfers in Angola

While informal solidarity mechanisms provide a kind of safety net at the community level, the formal social assistance system in Angola is still rudimentary. According to data from IBEP 2008-2009, 12 per cent of households receive some form of assistance. However, the bulk of this (8.2 per cent) comes as gifts from family and friends. Much less is provided by the Government (2.5 per cent), churches (1.0 per cent) or NGOs (0.5 per cent), as can be seen in Figure 7.2.
The main social transfer programme in Angola is the Programa de Apoio Social (PAS), which provided in-kind assistance to about 600,000 people in 2011 according to government data. This is equivalent to about 3 per cent of the total population or 8 per cent of the population living in monetary poverty. Like other much smaller social assistance programmes, the PAS is overseen nationally by MINARS and managed operationally by the provincial directorates of social assistance and reinsertion in conjunction with staff of the municipios. In 2011, the PAS distributed 7,953 tons of food and non-food aid. Its main sub-component is the cesta básica (food basket), a food distribution facility that aims to improve the diet of vulnerable families. Distribution is irregular, fluctuating according to the availability of resources. The programme is implemented through contracts with private companies, which mainly procure imported food products for distribution to the provinces and does not incentivize national food production by procuring from local markets. Among the other commodities distributed by the PAS are zinc sheets to assist construction by returning refugees and persons affected by disasters, various types of technical kits for the promotion of productive activities by vulnerable people, and mobility aids and other equipment for persons with disabilities. Another MINARS initiative, the Programa de Geração de Trabalho e de Rendimento, assists vulnerable beneficiaries to become more self-reliant by facilitating access to training and by providing kits. However, due to its technical, organizational and economic complexity, the number of beneficiaries is very small (about 19,000 in 2011). Most of assistance in Angola is short term and sporadic, being provided mainly to respond to temporary shocks or in a few cases to provide one-off support to kick-start productive activities (Santos 2012 and OPM 2013a).

In line with the draft NSAP which includes cash transfers as a measure to reduce poverty and vulnerability, a new cash transfer programme is being piloted and other programmes are planned to enter the design stage in the near future. In 2014 the National Poverty Reduction Programme under the Ministry of Commerce started piloting a cash transfer programme that provides poor families with 5,000 kwanzas (US$50) per month through a pre-paid card (Cartao Kikuia) for the purchase of a pre-defined set of goods (food, education materials, etc.) in stores established for this purpose by the Government. At the time of writing, one store is reportedly operational and two others are under construction; more detailed information on the implementation of this programme is not yet available. Targeting and selection of programme beneficiaries is done by local authorities and it is not clear whether adequate criteria were defined and are used to ensure that the targeting of beneficiaries is effective in enrolling the most vulnerable families. In 2014 MINARS started implementation of a four-year programme (APROSOCC) funded by the European Union in partnership with UNICEF that includes a pilot cash transfer programme targeting vulnerable children under the age of 5. The design stage for the pilot cash transfer programme is forecasted to start in 2015. Other cash transfer projects of smaller scale have been implemented in recent years in Angola; a pilot project in Cunene in 2010-2011 targeted poor families affected by HIV and AIDS. The only cash transfer that is currently legislated in Angola (Law no 6/98 of 7 August 1998) – a subsidy for persons with disabilities – is still not operational after 16 years because the regulations for implementation were never adopted.
7.3 Developing and scaling up cash transfer programme in Angola

Setting up and progressively taking a well-designed and implemented cash transfer programme to scale would accelerate progress in reducing poverty and vulnerability in Angola. Angola is at a turning point in its development. The immediate post-conflict tasks of humanitarian assistance, including support for the return and resettlement of refugees and displaced persons, have been accomplished, and attention is now turning to the long-term challenge of reducing the structural vulnerability of the poor. A large-scale cash transfer programme that is soundly designed and well implemented would not only raise the consumption of poor households, but also facilitate their access to basic social services, improve these households’ investments in their children, enable them to participate in economic growth and help to reduce the inequalities in Angolan society.

The first step towards the establishment of such a system was the adoption of the Basic Law on Social Protection (Law no 7/04 of 15 October 2004). This law envisaged “basic social protection” as comprising social assistance programmes to “promote the wellbeing of individuals, families and communities, prevent situations of deprivation and marginalization, and guarantee minimum levels of subsistence and dignity”. These programmes would constitute the first level of a three-tiered system. The other two levels include “compulsory social protection”, which refers to the contributory social security schemes for formal sector workers, and “complementary social protection”, which covers private and other voluntary social security schemes. Law no 7/04 identifies a number of potential target groups: individuals and families in extreme poverty, women, children and adolescents in situations of vulnerability, old people in situations of physical dependency or living in isolation, persons with disabilities, persons facing situations of social exclusion and unemployed persons at risk of marginalization. The law was short on detail, however, providing little information on the specific types of programmes to be set up.

In line with what is established in the Plano Nacional de Desenvolvimento (PND), the draft NSAP provides substantive content to the primary tier of basic social protection envisaged by Law 7/04. Developed by MINARS with assistance from UNICEF, the draft policy was presented to a national social protection conference in September 2013 (MINARS 2013). It aims to build on the constitutional obligations of the State to promote social development and the commitments in Law no 7/04 regarding basic social protection. The draft Policy sets a broad objective for the national social assistance system:

“...to establish a framework of social assistance so as to guarantee to individuals and households in situations of vulnerability and deprivation a dignified standard of living, access to basic services, the protection of their social rights, the reduction of risks and their negative effects, and the strengthening of the economic and social resilience of vulnerable individuals and households on a predictable and sustainable basis.”

The policy combines the strengthening of social care services and the establishment of a system of social transfers with institutional reforms. The proposals for developing more effective social care services have already been discussed in Chapter 6. With respect to social transfers (pillar 1 of the Policy), the specific objective is to “improve the standard of living of the most vulnerable families and individuals”. The Policy reaffirms the commitment in Law no 6/98 of 7 August 1998 to provide subsidies for persons with disabilities and, given the current restriction of old age pensions to the small minority of formal sector retirees with contributory pension rights, it also provides for the establishment of a state-financed social pension, as in the other middle-income SADC countries.

119 Notably Article 21 addresses the “adoption of criteria for the redistribution of wealth that benefit the citizens and in particular the most vulnerable and needy groups in society”.
The Policy gives special attention to grants for young children, recognizing the importance of risk and deprivation at young ages and the potential developmental impact of investments in human capital during early childhood. The Policy envisages establishing a system of child grants; however, given the high proportion of children in the population and the potentially high fiscal cost if all children were to receive grants, the Policy opts for a progressive implementation strategy, beginning with younger children aged four and under. This approach, which is similar to that pursued by South Africa at the start of the CSG in 1998, recognizes the importance of supporting early childhood survival and development, when the risks to children are greatest and the pay-back on improvements in child nutrition in particular are especially high.\textsuperscript{120}

Child grants will become progressively more affordable in Angola due to demographic changes and high rates of long-term economic growth. Demographic trends are a fundamental driver of the cost of social protection programmes. As Chapter 2 discussed, the population is growing quickly at an estimated 3.3 per cent per annum, and children under 15 currently account for about 45 per cent of the total population. However, the age composition of the population is likely to change over the coming decades, as fertility rates are expected to decline and life expectancy to increase (see Figure 7.3).

As a result of lower fertility and increased life expectancy, the national dependency ratio will decline, while the proportion of the population that is working-age swells and the proportion of children under age 15 contracts, reflecting earlier fertility and birth rates. More simply put, there are currently approximately two people of working age for each person too young or too old to work. By 2030, there will be around 2.3 Angolans of working age for each Angolan outside the labour force. If a high rate of GDP growth is sustained, as the dependency ratio declines it should become increasingly easy for Angola to fund a child grant programme over the next three to four decades.

A number of issues must be carefully considered to ensure that cash transfer programmes that will be implemented in Angola are able to reach the expected results. This includes adequate provisions for eligibility criteria (targeting), the registration of beneficiaries, transfer amounts, programme costs and fiscal sustainability, and institutional capacity.

\textsuperscript{120} The first 1,000 days of life are critical to children’s cognitive development and later their learning achievement in school, their productivity and earnings in adult life, and on a cumulative level have important consequences for national economic growth and development.
• **Targeting.** Governments developing social transfer programmes must decide if and how to target assistance. As noted above, most of the larger State-financed cash transfer programmes in southern Africa are categorical in nature, directed at children, the elderly and persons with disabilities. This is the approach set out in the draft NSAP. Some of these programmes, such as the social pensions in Botswana, Lesotho and Mauritius, are universal, while others like the pensions and child grants in South Africa apply a poverty filter. Poverty targeting in countries like Angola is notoriously difficult, costly and prone to large errors, due to weak administrative capacity and the complexity of targeting methods, the large scale of the informal sector, and the inherent difficulty of assessing household income or wealth. Above all, the weak differentiation of household living standards across the bottom deciles of the population poses challenges for poverty targeting. Any poverty-based targeting mechanism would be likely to produce high inclusion and exclusion errors in this context. Simple demographic targeting is far simpler and cheaper. Another option is to target the most deprived geographical areas, although geographic targeting runs the risk of being politically sensitive.

• **Registering beneficiaries.** Whatever the targeting method used, it is essential to set up an efficient and accurate registration system. In a context where many of the poorest individuals do not have identification documents and information systems are weak, this can be challenging. The rollout of large social transfer programmes will require parallel investments to strengthen the civil registration system and assistance to potential beneficiaries to obtain IDs, birth certificates or other identity documents (see Chapter 6). While adequate protection against fraud must be built into the system design, it is also vital to ensure that procedures are not so stringent that they inadvertently exclude eligible individuals. Innovative approaches from the region include Lesotho’s old age pension which uses voter registration cards and consultation with local chiefs to verify the identity and ages of individuals. Beneficiaries will need to be issued an identification number or card and their details input to a management information system (MIS) that must be built from scratch in Angola.

• **Determining the transfer amount.** Another critical issue is the amount of cash to be transferred to beneficiaries. The transfer must be sufficiently large to achieve the programme’s objectives, but the amount must also balance budget implications (affordability) with what is socially acceptable in the country context. Evidence shows that in order to have an impact the amount of the transfer needs to be at least 20 per cent of the level of household consumption. As the table in Box 7.1 shows, the size of transfers varies greatly between countries and within the African region. Typically, the richer countries are more generous in their transfers, reflecting both healthier fiscal positions and the higher cost of living in these countries. It is important to build a mechanism for periodic adjustments in transfer amounts into the programme design to avoid their value being eroded by inflation.

• **Cost and financial viability.** African governments, and particularly finance ministries, are inevitably concerned about the financial implications of introducing large non-contributory social protection programmes. These concerns are due to the fact that once introduced, these programmes may be politically unpopular to remove and therefore commit the government to long-term financial liabilities. As part of the preparations for the NSAP, cost estimates for various social transfer options were produced (OPM 2013c). It is reasonable to conclude that these programmes are potentially affordable for Angola, especially given the projected demographic and economic trends discussed above. In Angola, ‘social protection’ broadly defined, accounted for 11 per cent of the 2013 state budget. But most of this was spent on fuel subsidies (OPSA, 2013). These expensive and regressive subsidies, amounting to 4.8 per cent of GDP in 2013, benefit the richer segments of society (IMF 2014). The Government has recently embarked on a progressive phasing-out of these subsidies which should free up substantial resources to expand social transfers and other social spending.

---

121 An analysis of policy and technical options for social transfers, carried out as part of the preparations for the National Social Assistance Policy, used a proxy means test (PMT) and found that a child grant targeted to children under 5 in the 1st quintile would incorrectly exclude 46 per cent of that target group, while 32 per cent of the beneficiaries would be from other quintiles and so be included in the programme by error (OPM 2013c).
• **Institutional capacity.** The management and delivery of social transfers requires strong administrative systems for identifying and registering beneficiaries, making payments and other procedures. A computerized MIS system is important, as well as efficient payment mechanisms, which many countries outsource to institutions such as the post office, banks, micro-finance institutions or mobile phone companies. While many governments face capacity constraints, evidence shows that when social transfers are prioritized by national governments, they are able to deliver these transfers at scale. A few positive examples amongst many include the PSNP in Ethiopia and the social pensions in much of Southern Africa. One key insight from these experiences is the need to keep social protection programmes simple and to avoid complex targeting and payment mechanisms. It is also necessary to invest in building the required systems. A prerequisite for a successful social transfer programme is to clearly define institutional roles and responsibilities. The available evidence suggests that separating programme implementation from policy development and oversight can increase efficiency. In South Africa, for example, management of social transfer programmes is the responsibility of a specialized institution, the South African Social Security Agency (SASSA), and Mozambique has a similar body to deliver its Basic Social Subsidy Programme (PSSB). In Angola, the draft NSAP articulates the intention to take this approach, detailing that a National Social Assistance Institute (INAS) will be set up to implement social transfers from central to município level so as to ensure that transfers are managed in a unified transparent manner and are reliable and predictably delivered to beneficiaries without delays. A further important element is to ensure that there is a system and sufficient capacity to conduct strong monitoring of programme implementation as well as to assess the impact of the programme and use this information for improving design and implementation.

### 7.4 Summary of priority actions

The setting up and progressive scaling up of well-designed and implemented cash transfer programmes — as proposed in the draft NSAP — would accelerate Angola’s progress in poverty reduction and human development and address some of the financial barriers to access basic social services.

The adoption of the NSAP is the first step required to strengthen non-contributory social protection, as this policy provides the framework within which detailed planning and capacity-building for implementation can move forward. **Focus should then shift to adequate preparation for implementation of the measures included in the Policy.** This will require the following specific actions:

1. **Create a specialised national institution responsible for managing implementation of social transfers.** The creation of such institute is already foreseen in the NDP 2014-2019. Indeed, experience from other countries shows that the presence of a dedicated institution to coordinate operations can play a crucial role for the success of cash transfers and other social assistance interventions (successful examples of such institutions in the region include South Africa and Mozambique).

2. **Conduct careful analysis and decisions to ensure that programme design and implementation is sound and is based on lessons learned from other countries.** A large body of international evidence shows that sound design and implementation is crucial in order for the cash transfer programmes to deliver the expected results in term of poverty reduction and better redistribution of resources. This includes the early establishment of clear, well informed criteria for targeting and registration of beneficiaries as well as a well-functioning M&E system.

3. **Cost programmes on the basis of studies and informed decisions on the value of transfer amounts and their possible indexation, accounting for cost-efficiency, cost-effectiveness and financial sustainability of the programmes;**

4. **Invest in building the administrative capacity and systems needed to implement the social protection programme, including the design and set-up of a computerized management information system and mechanisms for paying transfers to beneficiaries.**

5. **Allocate sufficient government funds,** facilitated by curtailing expensive and regressive fuel subsidies. A review of cash transfer programmes in sub-Saharan Africa showed that allocation to these programmes varies between 0.3 per cent and 2.5 per cent of GDP.
Chapter 8.
Conclusions and recommendations

Emerging from a period of post-conflict reconstruction with substantial government resources, this analysis overwhelmingly shows that Angola stands to maximize the quality and longevity of progress by directing its focus and investments towards equity in social development. To do so, every policy and funding decision must deliberately target the most vulnerable and destitute segments of the population to protect their rights and promote wellbeing, thereby ensuring the sustainability of development gains.

Since the end of the war in 2002, Angola has enjoyed unprecedented economic prosperity and social stability. These conditions combined with the active engagement of the State in development and considerable national resources, have paved the way for dramatic improvements in socio-economic indicators in Angola. However, Angola still lags far behind other upper middle-income countries in Sub-Saharan Africa on child survival, health, education and water and sanitation, and in many cases the coverage of services falls well below averages for the entire region. Further, massive disparities are seen within Angola: poorer households and those in rural areas are consistently worse off in terms of access to social services and health, education and protection outcomes for children. Angola now faces the challenge to consolidate progress made to date, expand the benefits of economic growth to the whole population, and increase the pace, efficiency, and sustainability of social development.

Accelerating progress in social development requires tackling the severity of inequality in the economic and social conditions of different populations in Angola. Inequality is not only experienced by those who are worse off, but is harmful to society and the country as a whole: highly unequal societies tend to grow more slowly than those with greater equity, are less successful in sustaining growth, and recover more slowly from economic downturns. When inequality and disparity reach extreme levels, they foment discontent that can lead to political instability and generate conflict.

Prioritising the most vulnerable members of the population will inherently have a greater impact as investments where deprivation is most severe can yield meaningful results at a large scale. The redistribution of wealth and reducing inequality are among the stated priorities of the Government of Angola and the translation of political priority into action is both the greatest challenge and opportunity now facing the country.

Several interventions emerged in this analysis that would enable Angola to accelerate social development while reducing inequality. The remainder of this chapter presents 24 priority interventions which are simple to implement, proven to be effective in developing countries, appropriate in the Angolan context, and in line with existing political commitments.
Summary of recommendations

Child survival and health

Tackling high rates of child mortality should be a national priority. Mortality among young children in Angola is very high. Interventions that decrease child mortality also contribute to the healthy development of children into adults able to reach their full potential. To accelerate reductions in child mortality, redoubled efforts will be needed across all the dimensions of health and wellbeing including the supply and quality of health services, household food security and child nutrition, access to water and sanitation, and families’ health-related behaviours. Priority recommendations include:

1. Scale up and strengthen high-impact interventions through an integrated package of high-impact promotional, preventive and curative health services. Priority should be given to:
   - Routine Immunization (EPI). In Angola less than one in four children below the age of 2 (23 per cent) are fully vaccinated. Greater attention is required to ensure that cold chain equipment is reliable, especially in peripheral health units. In addition, outreach strategies need to be scaled up to reach the most underserved areas.
   - Increase coverage of malaria prevention and treatment services. Prevention interventions should aim to increase the use of insecticide-treated bed-nets and indoor residual spraying to protect children and their families from malaria.
   - Improve coverage and quality of maternal health services, especially in rural areas, to increase the proportion of deliveries that take place in health facilities and ensure the referral and transport of women with high-risk pregnancies to facilities with emergency obstetric services. Improved maternal health services should include community-based postnatal care for mothers and newborns in the first week after birth.

2. Strengthen capacity to deliver nutrition programmes. The comprehensive package of nutrition interventions identified in national policy documents needs to be translated into operational reality. Central, provincial and municipal levels must be equipped with human resources proportionate to the scale of malnutrition in Angola. Adequate national and sub-national capacity will be essential to operationalise the official package of nutrition interventions including:
   - Reduction of micronutrient deficiencies through twice-yearly vitamin A supplementation, enforcement of the legislation on salt iodization, zinc to treat diarrhoea, and iron folic acid to prevent maternal anaemia.
   - Prevention and treatment of acute malnutrition through expanded coverage of in-patient facilities, outpatient therapeutic programmes and community management.
   - Behaviour-change interventions promoting early breastfeeding and hygiene.

3. Scale up the prevention and treatment of HIV and AIDS in children and adolescents as part of a broader drive to contain the disease and its impact. Angola has so far been spared a crippling national HIV/AIDS epidemic, however complacency is dangerous: low coverage of prevention and treatment services have failed to reduce HIV incidence and new infections appear to be increasing among children in particular. Knowledge and behaviours among the general population are still not conducive to preventing HIV transmission, while testing and treatment coverage rates remain very low, especially among children. Only 14 per cent of the estimated number of HIV-positive children aged 0-14 receive treatment. The actions to be taken are already set out in the accelerated response strategy, which aims to eliminate new infections in young children by 2015. Priorities include the rapid scale-up of PMTCT, HIV testing and treatment, as well as redoubled communication efforts to improve knowledge and practices.

4. Set up and rapidly expand community-based management of childhood diseases. Health policy in Angola inadequately addresses the promotion, prevention and treatment of common childhood diseases at community level through community health resources. Documented experiences from countries all over the world and in sub-Saharan Africa (Ethiopia, Zambia, South Africa, Mali, Niger, etc.) have shown that community health workers and traditional birth attendants are a vital resource in the implementation of public health programmes such as malaria control and immunisation.
5. **Expand coverage of improved water sources and sanitation facilities, in particular in rural areas and peri-urban slum settlements.** To consolidate progress made in extending piped water and sewerage systems in the cities and small water systems in rural towns, priority should be given to the following actions:

- Drilling and maintenance of village boreholes to reduce extensive use of surface water sources in rural areas.
- Expansion of the community water management model in villages and peri-urban areas to ensure community ownership and the sustainability of wells.
- Completion and implementation of the National Environmental Sanitation strategy.
- National scale-up of Community Led Total Sanitation (CLTS).
- Implementation of institutional and financial reforms to ensure urban water and sanitation systems are financially viable and pricing is equitable and to free resources for extending coverage of piped water to peri-urban areas.

6. **Strengthening primary health care.** The PNDS places a high priority on primary health care (PHC). To operationalise the political commitment to PHC, it will be necessary to improve budget allocations to and within the health sector, strengthen reforms and undertake large-scale capacity-building. Specific actions to strengthen PHC include:

- **Increase investment in health infrastructure to extend the network** of health posts and health centres in rural areas, especially in the most deprived eastern provinces, and in the peri-urban areas.
- **Increase human resources for health in rural areas** by providing training for large numbers of additional health staff and rational deployment to the provinces of the interior and rural areas. (Re)deployment must be supported by a well-conceived system of incentives for health personnel to work and remain in underserved areas.
- **Decisive action to end drug stock-outs**, through measures to improve forecasting and stock management and the procurement, storage and distribution of essential medicines.
- **Establishment of an effective referral system** from primary to secondary health facilities, especially for emergency obstetric care. Standardized protocols as well as transport (ambulances) will be crucial inputs for a functioning referral system.
- **Strengthen outreach** to bring services to remote and underserved communities, including through mobile teams.

7. **Scale up social communication interventions to improve knowledge and promote healthy behaviours for better child and maternal health.** The promotion of improved nutrition, reproductive health, and hygiene practices can have a major effect on the reduction of health risks and child mortality. The Family Competencies Programme offers effective platforms for expanding social communication with both large-scale campaigns using the media and community-level outreach to families through traditional authorities, churches, TBAs and community health workers, schools and social workers.

**Education**

Having achieved progress in increasing primary school enrolment, Angola needs to focus on improving quality, learning outcomes and equity in the education system. Priority actions to strengthen access to education and improve learning include:

8. **Invest greater resources in early childhood education including pre-school/ **iniciação**. Early childhood education is crucial to ensure that children start school ready to learn, and contributes to improved learning outcomes and lower rates of repetition in primary school. Currently, less than 0.01 per cent of public spending is dedicated to early childhood education, despite the fact that returns on investment at this level are significantly higher than at any other level of education. Angola needs to draw on regional best practices to strengthen the quality of **iniciação** and to develop and expand a sustainable, cost-efficient community-based pre-school model.
9. Improve the quality of education by scaling up training and support for teachers in the areas of child-oriented teaching, integrated pedagogy and learning assessment. While many more children are now in school, many children who start primary school are unable to finish, and many who do finish, leave school without basic reading skills. Angola needs to dramatically strengthen teacher training, supervision and school management. In-service training for teachers should be expanded through the use of pedagogical influence zones (ZIPs). Training should be accompanied by supportive supervision and strategies to motivate and retain teachers in underserved areas.

10. Accelerate investment in school construction and maintenance at all levels of general education and in particular in secondary education to keep pace with increased pupil numbers. The geographic targeting of new infrastructure must be improved to increase access to schools in rural areas and reduce geographical disparities. It is also important to ensure that schools are built according to agreed safety and sanitation standards. Schools should provide a safe and healthy learning environment for all children including girls and young women.

11. Increase demand for education through adoption of detailed regulations to enforce adherence to the principle of free primary education and community awareness activities to promote the value of education and the importance that children start school at the correct age and complete school.

12. Promote equity in the education system
   - Develop and enforce a policy framework to promote equal access for children with special needs. Clear directives for implementation should include teacher training, the provision of special learning materials and improvements to the physical accessibility of classrooms.
   - Pilot measures to promote girls’ education at secondary school level, particularly in rural areas.
   - Consider adjustments to the school calendar to accommodate agricultural cycles and mitigate the opportunity costs of education for children in rural areas.
   - Develop bilingual education for the early grades of primary school to reach children who do not speak Portuguese as their mother tongue.
   - Strengthen ‘second chance’ education and in particular the coordination and implementation of the Programa da Alfabetização e Acceleração Escolar (PAAE).

13. Strengthen planning, financing, management and monitoring of the education system. Improvements to the education management information system should incorporate data on learning outcomes and teacher performance. Training and support are also needed for school directors and school committees in education leadership in areas such as planning for school improvement, financial management and monitoring of students’ and teachers’ performance. The production and distribution of learning materials should be improved through stronger supply chain control.

14. Increase the overall allocation of public expenditure to education. Currently, just 8.2 per cent of all public spending in Angola goes to education, with 5.6 per cent allocated to primary education. Education allocation should aim to at least match the level of per-pupil expenditure in other middle-income SADC countries.

15. Assess school feeding programmes and roll out a viable national model as a solution to attract and retain children in schools particularly in deprived areas. School feeding programmes should strengthen community participation to raise awareness about a balanced and healthy diet and promote the procurement of local food.

Child protection
National policies and commitments provide a strong foundation to protect the rights and well-being of children in Angola. Legal commitments must be operationalised to ensure children grow up in a protective environment. An integrated child protection system should provide preventive and responsive services at local level and ensure all children are registered and able to realize their rights to protection and justice and access related services.
16. Establish a more effective child protection system through the provision of preventive and responsive services in front-line units.

- Adopt legislation defining the purpose, functions and procedures of front-line protection units, covering case management and referral systems.
- Introduce an official cadre of social workers within the staffing framework of municipal administrations and train and deploy adequate numbers of social workers to front-line protection units.
- Designate front-line protection units as budget units to receive direct financing and allocate adequate resources.

17. Empower informal child protection networks at community level as pillars of an integrated response with training and financial resources as well as appropriate guidelines to regulate their interaction with social services through referral systems.

18. Strengthen civil registration and vital statistics systems. More than 4 million Angolan children were not registered at birth and are thus prevented from accessing essential services and full citizenship rights. The Government of Angola recently embarked on a large-scale programme to modernize the civil registration system. In order for the programme to grant equitable access without discrimination to the right to identity, the legal and policy framework for registration needs to be improved. Most importantly, vital registration services must be scaled up beyond the major urban areas to reach more remote and underserved areas of the country. Well coordinated multi-sectoral strategies will be essential to expand access and service points for civil registration.

19. Design and implement an appropriate model for justice for children in all provinces that clearly designates institutional responsibilities and the procedures to be followed. Children entering in contact with the justice system should encounter specialised processes at the police and within the court system and social services that are adapted to their specific needs, rights, and vulnerabilities. The model should provide for the training of personnel and specific budget allocations for provincial courts to offer specialized protection for children.

Social protection

Non-contributory social protection measures, including cash transfers, should be strengthened and expanded as a strategy for better redistribution of resources, to address the financial barriers households face to access social services, and ultimately improve wellbeing in poor households and communities.

20. Ensure the expansion of social protection is guided by a cohesive sectoral policy, to avoid duplication and poor coordination of efforts by different government institutions. Once approved, the draft NSAP will provide a solid basis for the expansion of non-contributory social protection.

21. Base programme design and implementation on sound analysis and lessons learned from other countries. A large body of international evidence shows that cash transfer programmes achieve stated objectives only when they are based on rigorous design and implementation. The programme design must define appropriate and transparent criteria for targeting and registration of beneficiaries and establish strong information systems for monitoring and evaluation done from the level of the service providers.

22. Establish a specialised national institution responsible for managing implementation of social transfers. Experience from other countries highlights the importance of creating a specialised national body responsible for managing social transfers. The need for this institution is recognised in the National Development Plan (PND). It is also necessary to establish and progressively expand a network of front line units that provide an accessible point of entry for beneficiaries to access non-contributive social protection services and programmes.

23. Build the administrative capacity and systems needed to implement the social protection programme, including the design and set-up of a computerized management information system and mechanisms for transferring payments to beneficiaries.

24. Allocate sufficient government funds for the social protection programme. Financing can be facilitated by curtailing expensive and regressive fuel subsidies.
References


ADPP (no date) ‘Um conceito em debate’, Documentação e avaliação da efectividade de experiências com agentes comunitários de saúde e parteiras tradicionais em Angola, Ajuda de Desenvolvimento de Povo para Povo, for Ministry of Health and UNICEF


AN (2001) Lei de Bases do Sistema de Educação. Lei no 13/01 de 31 de Dezembro, Assembleia Nacional

AN (2002) Lei de Águas, Lei no 6/02 de 21 de Junho, Assembleia Nacional


Azancot de Menezes M (2010) Um olhar sobre a implementação da Reforma Educativa em Angola, estudo de caso nas províncias de Luanda, Huambo e Huíla, Luanda, Janeiro

Bachmann M.O. (2008) Cost-Effectiveness of Community-Based Therapeutic Care for Children with Severe Acute Malnutrition in Lusaka, Zambia, Medical school, University of East Anglia, UK


Candeeiro J (2013) Implementação das medidas de prevenção criminal para crianças em conflito com a lei – experiência realizada na Província da Huíla, Mosaiko – Instituto para a Cidadania

CESO Ci & GdA (2012) Plano Nacional de Formação de Quadros 2013-2020, versão final, Setembro

CNAC (2011) Angola: 11 Compromissos com a Criança, V Fórum Nacional sobre a Criança, Junho, Conselho Nacional da Criança

CNAPED (no date) Plano Nacional de Acções Integradas sobre a Deficiência, Conselho Nacional da Pessoa com Deficiência


CTCPAPT (2013) Relatório referente ao mês de Setembro de 2013, Comissão Técnica de Coordenação do Programa Água para Todos, October

Damon A & Glewwe P (2007) Three proposals to improve education in Latin American and the Caribbean: estimates of the costs and benefits of each strategy, report to the Copenhagen Consensus Center and the Inter-American Development Bank


DW (2011) Poverty and environmental vulnerability in Angola’s growing slums, City report for Luanda, Development Workshop, Luanda, November


Hanushek et al (2010) …


IMF (2013) Regional Economic Outlook: Sub-Saharan Africa, International Monetary Fund, Washington, DC, August


INE (2013a) Sistema de registo civil, Dados de 2010-2011, Instituto Nacional de Estatística, Abril
INE (2013b) Inquérito de Indicadores Básicos de Bem-estar – QUIBB 2011, Relatório analítico, Instituto Nacional de Estatística
McSweeney C, New M & Lizcano G (no date) UNDP climate change country profiles: Angola, http://country-profiles.geog.ox.ac.uk
MDG-F (2013) Final MDG-F joint programme narrative report: Children, food security and nutrition in Angola, MDG Achievement Fund
MEA (no date) Programa Água para Todos, Plano de Acção, Ministério da Energia e Águas
MED (2011a) Anuário PAEP 2010, edição de trabalho, Gabinete de Estudos, Planeamento e Estatística, Ministério da Educação, Novembro
MED (2011b) Memorando sobre a preparação do ano lectivo de 2012, Ministério da Educação
MED & UNICEF (no date) Estudo preparatório para a regulamentação da Lei 13/2001 sobre a gratuidade do ensino primário em Angola, Ministério da Educação & UNICEF
MED, INIDE & ADPP (2006) Resultados da avaliação das aprendizagens de alunos da 2a classe da reforma educativa e do desempenho de seus professores, Ministério da Educação, INIDE & Ajuda de Desenvolvimento de Povo para Povo
Micronutrient Initiative (2009) Investing in the future, A United call to action on vitamin and mineral deficiencies, Global Report
MINARS (2013) Política Nacional de Assistência Social, draft, Ministério da Assistência e Reinsençao Social
MINARS (no date) Estratégia de Intervenção para a Inclusão Social da Criança com Deficiência, Ministério da Assistência e Reinsençao Social
MINARS (no date) Legislação existente sobre a pessoa portadora de deficiência, Ministério da Assistência e Reinsençao Social
MINARS (no date) Contributo relativo ao Conselho Nacional de Pessoa com Deficiência (CNPED), Direcção Nacional de Integração da Pessoa Portadora de Deficiência, Ministério da Assistência e Reinsençao Social
MINEA (no date) Programa Água para Todos, Plano de Acção, Ministério da Energia e Águas
MINFAMU (2013) 2a Conferencia Nacional sobre a Mulher e a Violência Doméstica, Comunicado final, Ministério da Família e Promoção da Mulher
MINFIN (2014) Orçamento cidadão - 2014, Um compromisso do Governo com o cidadão, Ministério das Finanças
MINPLAN (2010a) Estratégia de Combate à Pobreza, Crescimento e Estabilização Económica, Ministério do Planeamento, Luanda, 28 de Fevereiro
MINPLAN (2010b) O mundo que queremos, Relatório sobre os Objectivos de Desenvolvimento do Milénio, Ministério do Planeamento, Setembro
MINPLAN (2012) Plano Nacional de Desenvolvimento, Ministério do Planeamento e do Desenvolvimento Territorial, Dezembro
References

MINSA (2011a) Immunization Multi-Year Plan 2011-2015, May
MINSA (2011b) National Nutrition Strategy for Early Childhood, National Public Health Department, Ministry of Health, June
MINSA (no date) Pacote essencial de saúde materno infantil, Direcção Nacional de Saúde Pública, Ministério da Saúde
MINSA (no date) ‘Um conceito em debate’: Documentação e avaliação da efectividade de experiências com agentes comunitários de saúde e parteiras tradicionais em Angola
Mosaiko (2013a) Implementação das mediadas de prevenção criminal para crianças em conflito com a lei – experiência realizada na Província de Huíla, Abril
Mosaiko (2013b) Implementação de medidas de prevenção criminal para crianças em conflito com a lei
OPM (2013a) Apoio à elaboração da Política Nacional de Assistência Social, Diagnóstico e prioridades, Junho
OPM (2013c) Apoio à elaboração da Política Nacional de Assistência Social, Nota Conceptual 2: Papel, impactos, custos e viabilidade de diversas opções de transferências sociais monetárias, Oxford Policy Management, Agosto
OPM (2013d) Apoio à elaboração da Política Nacional de Assistência Social, Nota institucional, Oxford Policy Management, Junho
Pestana N & Orre A (undated) Visão panorâmica sobre o processo de descentralização em Angola, unpublished paper
RdA (2003b) ‘Lei de Bases da Protecção Civil’, Lei no 28/03 de 7 de Novembro, Diário da República, I Série, no 83, 7 de Novembro
RdA (2010a) ‘Constituição da República de Angola’, Diário da República, I Série, no 23, 5 de Fevereiro
RdA (2010b) ‘Lei da Organização e do Funcionamento dos Órgãos de Administração Local do Estado’, Lei no 17/10 de 29 de Junho, Diário da República, I Série, no 142, 29 de Julho
RdA (2012b) ‘Lei sobre a Protecção e Desenvolvimento da Criança’, Lei no 25/12 de 22 de Agosto, Diário da República, I Série, no 162, 22 de Agosto
RdA (2013a) Regulamento de abastecimento público de água e de saneamento de águas residuais
RdA (2013b) Regulamento da Lei contra a Violência Doméstica, Decreto presidencial no 124/13 de 28 de Agosto, Diário da República, I Série, no 165, 28 de Agosto
RdA (no date) Respostas às questões referentes ao primeiro relatório periódico de Angola (CCPRC/C/AGO/1), aprovada pelo Comité de Direitos Humanos em sua sessão 105, 9-27 de Junho de 2012
RdA (no date) Política Nacional de Saneamento Ambiental (PNSA), draft
RdA (no date) Estratégia Nacional de Prevenção e Combate a Violência contra a Criança, República de Angola
Santos G (2012) Avaliação dos programas de protecção social do Ministério da Assistência e Reinserção Social MINARS, Banco Mundial
Schulmeyer MA (2013) Estudo sobre as crianças em risco de abandono participantes do Programa de Alfabetização e Aceleração Escolar – PAAE, relatório sobre as análises, 13 de Abril
Sykes O (2013) Rural vulnerability, climate change and adaptation in Angola, report for Christian Aid, June
UN (2009) The global financial crisis and its impact on the work of the UN system, UN System Chief Executives Board for Coordination, April
UN (no date) Breve análise da pobreza em Angola com base nos rendimentos e nas privações, Um contributo para a consulta nacional pós-ODM em Angola, Coordenação das Nações Unidas em Angola
UNAIDS (2013) 2013 Progress report on the global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive
UNICEF (2011b) Programme of Assistance to Primary Education (PAEP), Teacher Training Component, 2nd Interim Report for the Delegation of the European Union, June
UNICEF (2012b) Accelerating progress towards universal and sustainable salt iodization in Angola by the end of 2012, report to USAID, PBA SC/2011/0112, October
UNICEF (2013) Angola poverty and equity profile, draft, March
UNICEF (no date) Estratégia de saída do UNICEF como subrecipiente e de apoio técnico ao PNCM no quadro da componente de distribuição de MTILS com o financiamento do Fundo Global para SIDA-Tuberculose-Malária
UNICEF (no date) Three year polio eradication exist strategy 2013-2015, UNICEF Angola
WHO (2012), Global costs and benefits of drinking-water supply and sanitation interventions to reach the MDG target and universal coverage, World Health Organization, Geneva
WHO (2013), Global update on HIV treatment 2013: results, impact and opportunities, World Health Organization, Geneva
WHO & UNICEF (2007) Accelerated child survival and development investment plan: Revitalizing Angola’s primary health services to achieve the health related Millennium Development Goals
World Bank (2013a) Social Safety Nets in Africa – A Review of the Experience in 20 Countries, draft, February
World Bank (2013b) Project Appraisal Document on a Proposed Credit in the Amount of SDR 48.80 million (US$75 million equivalent) to the Republic of Angola for a Learning for All Project, Report no 66598, 28 August
Annex A

Table A.1 Selected child and human wellbeing indicators: performance of upper middle-income Sub-Saharan African countries

Latest available data (see sources for details)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Angola</th>
<th>Botswana</th>
<th>Gabon</th>
<th>Namibia</th>
<th>South Africa</th>
<th>Sub-Saharan Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child mortality (per 1,000 live births)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>164</td>
<td>53</td>
<td>62</td>
<td>39</td>
<td>45</td>
<td>98</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>100</td>
<td>41</td>
<td>42</td>
<td>28</td>
<td>33</td>
<td>64</td>
</tr>
<tr>
<td>Neonatal mortality rate</td>
<td>45</td>
<td>29</td>
<td>25</td>
<td>18</td>
<td>15</td>
<td>32</td>
</tr>
<tr>
<td>Lifetime risk of maternal mortality (1 in)</td>
<td>39</td>
<td>220</td>
<td>130</td>
<td>160</td>
<td>140</td>
<td>39</td>
</tr>
<tr>
<td><strong>Nutrition (% of children &lt;5)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic under-nutrition (stunting)</td>
<td>29</td>
<td>31</td>
<td>17</td>
<td>29</td>
<td>33</td>
<td>38</td>
</tr>
<tr>
<td>Acute under-nutrition (wasting)</td>
<td>8</td>
<td>7</td>
<td>3</td>
<td>8</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Underweight (weight for age)</td>
<td>16</td>
<td>11</td>
<td>6</td>
<td>17</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td><strong>Maternal health (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Births in health facilities</td>
<td>51</td>
<td>99</td>
<td>90</td>
<td>81</td>
<td>89</td>
<td>48</td>
</tr>
<tr>
<td>Births assisted by health personnel</td>
<td>57</td>
<td>95</td>
<td>89</td>
<td>81</td>
<td>91</td>
<td>50</td>
</tr>
<tr>
<td>Antenatal consultations (1+)</td>
<td>86</td>
<td>94</td>
<td>95</td>
<td>95</td>
<td>97</td>
<td>78</td>
</tr>
<tr>
<td>Antenatal consultations (4+)</td>
<td>57</td>
<td>73</td>
<td>78</td>
<td>70</td>
<td>87</td>
<td>48</td>
</tr>
<tr>
<td>Total fertility rate (number)</td>
<td>6.3</td>
<td>2.7</td>
<td>4.1</td>
<td>3.1</td>
<td>2.4</td>
<td>4.9</td>
</tr>
<tr>
<td><strong>Child health (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPT3 vaccine (aged 12-23 months)</td>
<td>91</td>
<td>96</td>
<td>82</td>
<td>84</td>
<td>68</td>
<td>71</td>
</tr>
<tr>
<td>Antimalarial treatment (children &lt; 5 with fever)</td>
<td>28</td>
<td>…</td>
<td>26</td>
<td>20</td>
<td>…</td>
<td>37</td>
</tr>
<tr>
<td>Sleeping under ITNs (aged &lt; 5)</td>
<td>26</td>
<td>…</td>
<td>39</td>
<td>34</td>
<td>…</td>
<td>36</td>
</tr>
<tr>
<td><strong>HIV/AIDS (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult HIV prevalence rate</td>
<td>2.3</td>
<td>23.0</td>
<td>4.0</td>
<td>13.3</td>
<td>17.9</td>
<td>4.5</td>
</tr>
<tr>
<td>PMTCT coverage rate</td>
<td>39</td>
<td>95</td>
<td>70</td>
<td>94</td>
<td>83</td>
<td>64</td>
</tr>
<tr>
<td><strong>Water &amp; sanitation (% of population)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using improved sources of water for drinking</td>
<td>53</td>
<td>97</td>
<td>88</td>
<td>93</td>
<td>91</td>
<td>63</td>
</tr>
<tr>
<td>Using improved sanitation facilities</td>
<td>59</td>
<td>64</td>
<td>33</td>
<td>32</td>
<td>74</td>
<td>30</td>
</tr>
<tr>
<td><strong>Education (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary NAR, boys</td>
<td>80</td>
<td>86</td>
<td>87</td>
<td>91</td>
<td>…</td>
<td>73</td>
</tr>
<tr>
<td>Primary NAR, girls</td>
<td>78</td>
<td>88</td>
<td>87</td>
<td>93</td>
<td>…</td>
<td>71</td>
</tr>
<tr>
<td>Secondary NAR, boys</td>
<td>29</td>
<td>36</td>
<td>50</td>
<td>47</td>
<td>…</td>
<td>34</td>
</tr>
<tr>
<td>Secondary NAR, girls</td>
<td>27</td>
<td>44</td>
<td>58</td>
<td>62</td>
<td>…</td>
<td>32</td>
</tr>
<tr>
<td>Adult literacy rate</td>
<td>69</td>
<td>85</td>
<td>89</td>
<td>76</td>
<td>93</td>
<td>59</td>
</tr>
<tr>
<td>Female as % of male literacy</td>
<td>69</td>
<td>101</td>
<td>93</td>
<td>105</td>
<td>98</td>
<td>74</td>
</tr>
<tr>
<td><strong>Child protection (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged in child labour (age 5-14)</td>
<td>20</td>
<td>9</td>
<td>13</td>
<td>…</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Birth registered (aged &lt; 5)</td>
<td>31</td>
<td>72</td>
<td>90</td>
<td>78</td>
<td>95</td>
<td>44</td>
</tr>
</tbody>
</table>

### Table A.2 Urban-rural disparities in child and human development indicators

<table>
<thead>
<tr>
<th>Category</th>
<th>Urban</th>
<th>Rural</th>
<th>National</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child and maternal mortality, 2008-2009</strong> (per 1,000 live births)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>154</td>
<td>233</td>
<td>194</td>
<td>IBEP</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>95</td>
<td>138</td>
<td>116</td>
<td>IBEP</td>
</tr>
<tr>
<td><strong>Child malnutrition, 2007</strong> (% of children &lt;5, moderate and severe)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic under-nutrition (stunting)</td>
<td>20 Luanda, 30 other</td>
<td>33</td>
<td>29</td>
<td>NNS</td>
</tr>
<tr>
<td>Acute under-nutrition (wasting)</td>
<td>7 Luanda, 10 other</td>
<td>8</td>
<td>8</td>
<td>NNS</td>
</tr>
<tr>
<td>Underweight (weight for age)</td>
<td>13 Luanda, 14 other</td>
<td>18</td>
<td>16</td>
<td>NNS</td>
</tr>
<tr>
<td><strong>Maternal health, 2011</strong> (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Births in health facilities</td>
<td>74</td>
<td>25</td>
<td>51</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Births assisted by health personnel</td>
<td>76</td>
<td>35</td>
<td>57</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Prenatal consultation rate (1+ visits)</td>
<td>94</td>
<td>77</td>
<td>86</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Prenatal consultation rate (4+ visits)</td>
<td>71</td>
<td>41</td>
<td>57</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Total fertility rate (number)</td>
<td>4.6</td>
<td>7.7</td>
<td>6.3</td>
<td>MIS</td>
</tr>
<tr>
<td><strong>Child health (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children 12-23 months with complete EPI immunization, 2008-2009</td>
<td>43</td>
<td>12</td>
<td>29</td>
<td>IBEP</td>
</tr>
<tr>
<td>Children &lt;5 years with fever receiving antimalarial drugs, 2011</td>
<td>44</td>
<td>21</td>
<td>28</td>
<td>MIS</td>
</tr>
<tr>
<td>Children &lt;5 years sleeping under ITNs, 2011</td>
<td>29</td>
<td>24</td>
<td>26</td>
<td>MI</td>
</tr>
<tr>
<td><strong>Water and sanitation, 2011 (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population using improved sources of water for drinking</td>
<td>66</td>
<td>35</td>
<td>53</td>
<td>JMP</td>
</tr>
<tr>
<td>Population using improved sanitation facilities</td>
<td>86</td>
<td>19</td>
<td>59</td>
<td>JMP</td>
</tr>
<tr>
<td><strong>Education, 2011 (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary net attendance ratio</td>
<td>85</td>
<td>72</td>
<td>79</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Primary net attendance ratio, boys</td>
<td>86</td>
<td>73</td>
<td>80</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Primary net attendance ratio, girls</td>
<td>84</td>
<td>72</td>
<td>78</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Secondary net attendance ratio</td>
<td>44</td>
<td>8</td>
<td>28</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Secondary net attendance ratio, boys</td>
<td>44</td>
<td>11</td>
<td>29</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Secondary net attendance ratio, girls</td>
<td>43</td>
<td>6</td>
<td>27</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Adult literacy rate (aged 15+)</td>
<td>85</td>
<td>47</td>
<td>69</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Female literacy rate (aged 15+)</td>
<td>77</td>
<td>30</td>
<td>57</td>
<td>QUIBB</td>
</tr>
<tr>
<td><strong>Child protection (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children aged 10-17 engaged in child labour, 2011</td>
<td>9</td>
<td>32</td>
<td>30</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Children &lt;5 with birth registered, 2008-2009</td>
<td>33</td>
<td>29</td>
<td>31</td>
<td>IBEP</td>
</tr>
</tbody>
</table>

Sources: See last column.
### Table A.3 Disparities in child and human development indicators, by wealth quintiles

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child and maternal mortality, 2008-2009</strong> (per 1,000 live births)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>208</td>
<td>205</td>
<td>178</td>
<td>188</td>
<td>170</td>
<td>IBEP</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>124</td>
<td>122</td>
<td>108</td>
<td>113</td>
<td>103</td>
<td>IBEP</td>
</tr>
<tr>
<td><strong>Maternal health, 2011 (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Births in health facilities</td>
<td>20.1</td>
<td>29.4</td>
<td>54.1</td>
<td>67.2</td>
<td>87.0</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Births assisted by health personnel</td>
<td>26.4</td>
<td>40.3</td>
<td>60.4</td>
<td>73.2</td>
<td>84.0</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Prenatal consultation rate (1+ visits)</td>
<td>71.0</td>
<td>77.9</td>
<td>91.4</td>
<td>96.1</td>
<td>94.7</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Prenatal consultation rate (4+ visits)</td>
<td>32.2</td>
<td>43.0</td>
<td>59.1</td>
<td>74.4</td>
<td>78.8</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Total fertility rate (number)</td>
<td>8.0</td>
<td>7.3</td>
<td>7.6</td>
<td>6.7</td>
<td>4.5</td>
<td>MIS</td>
</tr>
<tr>
<td><strong>Child health, 2011 (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children &lt;5 years with fever receiving antimalarial drugs</td>
<td>16.8</td>
<td>18.2</td>
<td>21.6</td>
<td>32.7</td>
<td>41.5</td>
<td>MIS</td>
</tr>
<tr>
<td>Children &lt;5 years sleeping under ITNs</td>
<td>11.7</td>
<td>17.9</td>
<td>23.4</td>
<td>31.0</td>
<td>34.2</td>
<td>MIS</td>
</tr>
<tr>
<td><strong>Water and sanitation, 2011 (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population using surface water sources for drinking</td>
<td>60.3</td>
<td>37.3</td>
<td>21.0</td>
<td>4.3</td>
<td>0.7</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Population using open defecation</td>
<td>74.2</td>
<td>31.3</td>
<td>22.4</td>
<td>4.3</td>
<td>0.1</td>
<td>QUIBB</td>
</tr>
<tr>
<td><strong>Education, 2011 (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary net attendance ratio</td>
<td>66.6</td>
<td>72.6</td>
<td>80.5</td>
<td>85.6</td>
<td>88.9</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Secondary net attendance ratio</td>
<td>4.1</td>
<td>8.0</td>
<td>17.3</td>
<td>38.6</td>
<td>57.2</td>
<td>QUIBB</td>
</tr>
<tr>
<td>Adult literacy rate</td>
<td>40.6</td>
<td>53.6</td>
<td>63.5</td>
<td>73.8</td>
<td>86.8</td>
<td>QUIBB</td>
</tr>
<tr>
<td><strong>Child protection, 2008-2009 (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children aged 10-17 engaged in child labour</td>
<td>25.9</td>
<td>25.6</td>
<td>20.5</td>
<td>14.5</td>
<td>11.1</td>
<td>IBEP</td>
</tr>
<tr>
<td>Children &lt;5 with birth registered</td>
<td>27.0</td>
<td>27.3</td>
<td>32.1</td>
<td>31.0</td>
<td>42.9</td>
<td>IBEP</td>
</tr>
</tbody>
</table>

Sources: See last column.
Credits

Published by UNICEF
197 Rua Major Kanhangulo, Luanda, Angola

© United Nations Children’s Fund (UNICEF)
April 2015

Production: Julie Pudlowski Consulting
“Emerging from a period of post-conflict reconstruction with substantial government resources, this analysis overwhelmingly shows that Angola stands to maximize the quality and longevity of progress by directing its focus and investments towards equity in social development. To do so, every policy and funding decision must deliberately target the most vulnerable and destitute segments of the population to protect their rights and promote wellbeing, thereby ensuring the sustainability of development gains.” UNICEF (2015) Situation Analysis, Children and Women in Angola