Republic of Angola
MINISTRY OF PLANNING

The Millennium Development Goals

Progress Report 2010

September 2010

Republic of Angola

MINISTRY OF PLANNING

REPORT ON THE MILLENNIUM DEVELOPMENT GOALS

September 2010

LIST OF ABBREVIATIONS

ATV	Counselling and Voluntary Testing
DNEG/MED	National Department of General Education/Ministry of Education
DNSP	National Department of Public Health
FAO	UN Food and Agriculture Organization
IMF	International Monetary Fund
FNLA	Frente Nacional de Libertação de Angola
FNUAP	UN Population Fund (UNFPA)
GEPE	Studies, Planning and Statistics Office
IBEP	Integrated Survey of Population Welfare
INE	National Statistics Institute
INLS	National Commission for the Fight against Aids
M&E	Monitoring & Evaluation
MAPESS	Ministry of Public Administration, Employment and Social security
MED	Ministry of Education (MoE)
MICS	Multiple-Indicator Cluster Survey
MINARS	Ministry of Assistance and Social Reintegration
MIND	Ministry of Industry
MINFAMU	Ministry of the Family and Protection of Women
MINHOTUR	Ministry of Hotels and Tourism
MINPLAN	Ministry of Planning
MINSA	Ministry of Health
MPLA	Movimento Popular de Libertação de Angola
MDG	Millennium Development Goals
IOM	International Organisation for Migrations
WHO	World Health Organisation
UNAIDS	United Nations Joint Programme into HIV/AIDS
UNDP	United Nations Development Programme
TB	Tuberculosis
TOD	Directly Observed Therapy
UNDAF	United Nations Development Assistance Framework
UNESCO	United Nations Education, Science and Culture Organisation
UNICEF	UN Children's Fund
UNIFEM	United Nations Development Fund for Women
UNITA	União Nacional para a Independência Total de Angola
USAID	United States Agency for International Development
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome

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FOREWORD

By assuming the Millennium Development Goals (MDGs) commitment in 2000, the Government of Angola was aware of the challenges ahead: making, in less than 15 years, significant advances in the quality of life, promoting levels of development that were strong enough in an environment still suffering from the effect of a long period of military instability.

This report aims to describe the progress made in implementing the Millennium Development Goals (MDGs) between 2005 and 2010, based primarily on data provided by the Integrated Population Welfare Survey (IBEP) between 2008 and 2009, conducted by the National Statistics Institute (INE).

The report presents conclusions on progress in eight MDGs, on 18 international development goals and operational indicators, along with other relevant aspects of combating poverty and promoting the welfare of the population.

The goals and indicators make it possible to monitor and assess progress in the eight MDGs: (1) eradicate extreme poverty and hunger, (2) establish universal primary education, (3) promote gender equality and women's empowerment, (4) reduce mortality in children under five years of age, (5) improve maternal health, (6) combat HIV/ADS, malaria and tuberculosis, (7) ensure environmental sustainability, and (8) foster global partnerships for development.

In the analysis of each objective we discuss aspects of diagnosis and trends (prospects for the implementation of the objectives based on assessment of the current situation), challenges (the constraints that must be eliminated) and the most relevant policies and programmes implemented by the Angolan Government to attain the objectives.

The report's findings show that Angola has the best outcomes indicators for objectives 1, 2, 4, 5 and 8.

We also observed significant advances in promoting decent, honest employment. The increase in the rate of public investment contributed to these results by boosting economic growth. The redesigning of, and more effective implementation of, public policies were also linked directly to the MDGs and the strategic objectives of the National Plan.

Among the public policies that have been implemented, with the greatest impact on the MDGs are the promotion of political and economic stability, the pursuit of sustainable development, including diversification, decentralization and reduction of territorial and gender disparities, and the priority given to human development and improving the quality of life.

The methods and main instruments chosen to implement these policies included the strengthening of national institutions, training of human resources, reconstruction and improvement of basic infrastructures, including communications, roads, transport, energy and water, and better coverage and quality of education, healthcare and decent housing.

Events in 2008-2009, especially at the end of the analysis period, partially compromised efforts to reach the MDGs and the national strategic objectives. The adjustments have been encouraging and provide a glimpse into the continuity of the policies that produced the positive results by the Government of Angola in trying to attain the MDGs.

Overall, the comprehensive Biennium Plan was notable for reversing the trend of reducing poverty and hunger. Additionally, it is worth highlighting that poverty and hunger reduce productivity and constrain income growth, which in turn aggravates poverty and hunger.

Climate change will also have a negative influence on poverty, by compromising food security, agricultural activities, public health and education, the latter due to interruption of classes caused by bad weather.

These effects are accentuated in poor countries, because, as the UN document "Climate change and MDGs" clearly notes, there is a serious lack of necessary infrastructure to deal with the impact of these phenomena, such as storms barriers and water storage structures.

Taking into account the aspects mentioned above, we consider that development plans should pay greater attention to climate change by drafting laws and implementing policies and practices to protect the environment, especially disadvantaged communities who depend greatly on natural resources.

Attention should also be paid to designing and implementing public policies and programmes to reduce the disparities between urban and rural areas, with respect to the MDGs.

1. INTRODUCTION

This is the third report since the Angolan Government´s commitment towards the Millennium Development Goals (MDGs) in 2000 and reflects progress in this field between 2008-2009.

The two previous MDGRs, submitted in 2003 and 2005 respectively, provided some useful figures, despite the difficult post-war context, leaving gaps regarding 2000 baseline indicators.

Although knowing that this gap would undermine the complete presentation of the data, the results were assessed using related indicators and information, and important progress has been made in producing reliable statistics on the welfare of the population.

The 2010 MDGR Report takes advantage of the preliminary results of the Integrated Population Welfare Survey (IBEP) 2008-09, conducted by the National Statistics Institute (INE) to help analyse progress made on the MDGs since 2005.

In the second half of 2009, the Ministry of Planning established a working group to coordinate the preparation of this report, with assistance from the United Nations Development Programme (UNDP), INE and consultants.

Some of the key activities undertaken by this working group are: research to evaluate the possibilities of establishing prerequisites or baselines for the indicators, identification of alternative and complementary data sources, analysis of preliminary information from IBEP, design of indicators and tables for the IBEP information, and a preliminary assessment of MDG indicators, based on data from the IBEP and other available sources.

Consequently, this report has much higher quality information than the previous report and provides a more consistent and appropriate data series to assess the country's situation regarding the MDGs.

The Millennium Summit held in the year 2000, brought leaders of 189 states together to address some of the world’s most pressing challenges. They pledged to make the world a better place for all humanity by joining efforts to fight poverty, improve access to basic services, reduce the spread of diseases, and care for the environment.

The Millennium Declaration set the global agenda for the 21st century and established action-oriented targets around eight specific goals that are known as the Millennium Development Goals (MDGs). The Millennium Declaration was thus a reflection of the decisions and commitments of the world leaders and outlined a road map for progress towards 2015.

The MDGs, associated with the Millennium Declaration[1], are an articulated set of interconnected issues regarding the global agenda with time-bound targets and indicators. These objectives are divided into 18 international development goals which were established in 1996[2], incorporating other relevant aspects of combating poverty and promoting the welfare of the population.

The MDGs focus the efforts of the world community on achieving significant, measurable improvements in people's lives by establishing yardsticks for results: Eight Goals for 2015.

The eight Millennium Development Goals are given below:

1. TO ERADICATE EXTREME POVERTY AND HUNGER
2. ATTAIN UNIVERSAL PRIMARY EDUCATION
3. PROMOTE GENDER EQUALITY AND WOMEN'S SELF-HELP
4. REDUCE INFANT MORTALITY
5. IMPROVE MATERNAL HEALTH
6. COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES
7. ENSURE ENVIRONMENTAL SUSTAINABILITY
8. BUILD A GLOBAL DEVELOPMENT PARTNERSHIP

Table 1 shows the MDG goals and indicators.

The goals of the indicators associated with each of the eight objectives make it possible to monitor and evaluate progress in the following areas: eradicating extreme poverty and hunger, establishment of universal primary education, promoting gender equality and women's empowerment, reduction of mortality in children under five years old, improving maternal health, combating HIV/AIDS and other diseases such as malaria and tuberculosis, ensuring environmental sustainability, and fostering a global partnership for development.

This 2010 Report shows that Angola has showed progress in achieving their MDG targets in the following areas:

• **Objective 1 - To eradicate extreme poverty and hunger**
• **Objective 2 - To attain universal primary education**
• **Objective 4 - To reduce infant mortality**
• **Objective 5 - To improve maternal health**
• **Objective 8 - To build global partnerships**

As the Report will demonstrate, three objectives still require greater attention, namely,

[1] http://www.un.org/millennium/declaration/ares552e.htm
[2] http://www.paris21.org/betterworld/goals.htm

- **Objective 3 - To promote gender equality and women's self-help**
- **Objective 6 - To combat HIV/AIDS, malaria and other diseases**
- **Objective 7 - To improve maternal health**

This Report presents the country's performance in each of the eight MDGs by exploring them through the following criteria:

- **Diagnosis and trends**: It assesses the current situation and analyses the prospects for implementing the objectives;
- **Challenges:** It analyses the constraints that have to be overcome/eliminated so as to comply with the intended goals;
- **Policies and Programmes:** It indicates the most relevant policies and programmes created by the Angolan government to attain the objectives.

Table 1 - Millennium Project Objectives, Goals and Indicators

GOAL 1		
To eradicate extreme poverty and hunger	**Objective 1**	
	To reduce the percentage of the population with an income of less than a dollar a day by half between 1990 and 2015.	**Indicators** 1. *Percentage of the population with less than a dollar a day (values in purchasing power parity PPP)* 2. *Poverty differential ration (incidence x profound poverty)* 3. *Part of the poorest band in national consumption*
	Objective 2	
	To reduce the percentage of the population affected by hunger by half between 1990 and 2015.	**Indicators** 4. *Proportion of children under-five with under average weight* 5. *Percentage of the population with a diet under the minimum energy consumption level*
GOAL 2		
To attain universal primary education	**Objective 3**	
	To ensure that all children of both genders complete their primary education by 2015	**Indicators** 6. *Net percentage of enrolments in primary schools* 7. *Percentage of pupils who enrol in 1st grade and reach 5th grade* 8. *Literacy rate between 15 and 24 years old*
GOAL 3		
To promote gender equality and women's self-help	**Objective 4**	
	To eliminate the gender gap in primary and secondary education if possible by 2005 and in all levels of education by 2015.	**Indicators** 9. *Proportion of boys and girls in primary, secondary and higher education* 10. *Proportion of literate men and women of 15 to 24 years old* 11. *Percentage of women with paid jobs outside the agricultural sector* 12. *Proportion of women in parliament*
GOAL 4		
To reduce mortality in children under 5	**Objective 5**	
	To reduce the mortality rate of children under-five by two-thirds between 1990 and 2015	**Indicators** 13. *Mortality rate in children under-five* 14. *Infant mortality rate* 15. *Percentage of 1-year-old children vaccinated against measles*
GOAL 5		
To improve maternal health	**Objective 6**	
	To reduce maternity mortality rate by three-quarters between 1990 and 2015	**Indicators** 16. *Maternal mortality rate* 17. *Percentage of births in the presence of qualified medical staff*

Table 1 - Millennium Project Objectives, Goals and Indicators (Cont)

GOAL 6		
To combat HIV/AIDS, malaria and other diseases	**Objective 7**	
	To stop and begin reducing HIV/AIDS propagation by 2015	**Indicators** *18. Incidence of HIV/AIDS in pregnant women between 15 and 24 years old* *19. Rate of contraceptive use* *20. Number of orphan children due to HIV/AIDS*
	Objective 8	
	To stop and begin reducing incidences of malaria and other serious diseases by 2015	**Indicators** *21. Incidence rate and deaths due to malaria* *22. Percentage of the population in malaria risk areas that use effective prevention* *23. Incidence rate and deaths due to tuberculosis* *24. Percentage of cases of TB detected and cured by TOD (Short-term direct observation treatment)*
GOAL 7		
To ensure environmental sustainability	**Objective 9**	
	To integrate the principles of sustainable development into national programmes and policies to turn around the current trend of losing environmental resources	**Indicators** *25. Percentage of land covered in forests* *26. Areas of protected land to maintain biological diversity* *27. GDP per unit of energy used (as an indicator of energy efficiency)* *28. Carbon dioxide emission per capita*
	Objective 10	
	To reduce the percentage of the population without permanent access to drinking water by half by 2015	**Indicators** *29. Percentage of the population with sustainable access to improved water supplies.*
	Objective 11	
	To improve considerably the lives of at least 100 million slum dwellers by 2020	**Indicators** *30. Percentage of people with access to consolidated public health services* *31. Percentage of people with safe access to property*

Table 1 - Millennium Project Objectives, Goals and Indicators (Cont)

GOAL 8		
To build a global development partnership	**Objective 12** To continue developing an open, multilateral financial and commercial system that is regulated, foreseeable and non-discriminatory *(include the commitment to good governance, development and reduction of poverty - domestic and international)*	**Indicators** *Some of the indicators mentioned below will be assessed separately for the least developed countries, hinterland counties and developing island states* <u>*Public Development Aid*</u> *32. Net PDA as a percentage of the CAD donor's GNI (objectives of o.7% and .015% for the least developed countries)* *33. Percentage of PDA for basic social services (basic education, primary health care, nutrition, drinking water and public health)* *34. Percentage of PDA that is not attributed* *35. Percentage of PDA for the environment in small developing island states* *36. Percentage of PDA for the transport sector in hinterland states* <u>*Market Access*</u> *37. Percentage of exports (by amount not including arms) considered to be free of taxes and quotas* *38. Average tariffs and quotas on agricultural, textile and clothing products* *39. Agriculture and export subsidies and internal consumption of the OECD countries* *40. Percentage of PDA available to build commercial property* <u>*Debt Sustainability*</u> *41. Percentage of the official bilateral debt of the Most Indebted Poor Counties (MIPC) to be cancelled* *42. Debt service as percentage of exports of goods and services* *43. Percentage of PDA available to reduce debts* *44. Number of countries that satisfy the requirements of the MIPC and conclusions*
	Objective 13 To respond to the specific needs of the least developed countries *(Including access to a system without export rights and quotas for the least developed counties; a better programme to reduce the debt level of the most indebted countries and cancellation of official bilateral debt; and the concession of more generous public development aid to countries striving to reduce poverty)*	
	Objective 14 To respond to the special needs of countries with no coastline and small developing island states *(through the Barbados Programme and provisions of the 22nd General Assembly)*	
	Objective 15 To negotiate a wide-ranging solution to the debts of developing countries using national and international measures to make the debt more sustainable in the long term	
	Objective 16 To formulate and implement strategies that offer young people productive, decent work in cooperation with the developing countries	**Indicators** *45. Unemployment rate between 15 and 24*

Table 1 - Millennium Project Objectives, Goals and Indicators (Cont)

OBJECTIVE 8		
To build a global development partnership	**Objective 17**	
	To provide access to essential medicines at affordable prices to developing countries in cooperation with drug companies	**Indicators** *46. Percentage of the population with access to available essential drugs on a sustainable basis*
	Objective 18	
	To make access to the benefits of new technologies, particularly ICT accessible in cooperation with the private sector	**Indicators** *47. Telephone lines per 1000 inhabitants* *48. PCs per 1000 inhabitants*

2. EMERGING PRIORITIES AND THE MILLENNIUM DEVELOPMENT GOALS

The MDGs led to an unprecedented amount of commitments and partnerships towards improving the living conditions of billions of people and creating an environment that promotes peace and security.

The experience gained in almost ten-years regarding the targets shows that the strategies and actions have achieved the desired changes in living conditions of worldwide populations to some degree or another. The results analysed in this report on Angola are a consequence of this trend.

There are, however, new challenges at the end of this decade. The basic question is how to provide and even accelerate the efforts that have been made to comply with the MDGs against a background of economic crisis and climate change.

The question will be approached in this chapter to help world leaders reflect on the issue and design an agenda for concrete action at the Millennium Development Goals Summit in 2010.

International economic crisis and the MDG

The global context over the last two years has not been favourable to achieving the MDGs, since global instability and low economic growth has put the continuity of development gains in previous years at risk.

However, some MDGs reports note progress and call attention to the path that must be followed, taking the global context into account.

It also shows that in 2008-2009, millions of people started living in extreme poverty, compared to what was predicted before the economic crisis and the positive trend in eradicating hunger since the early 90s.

Extreme poverty and chronic hunger makes development more difficult. Poverty leads to malnutrition and disease, which reduces income and economic productivity. This, in turn, aggravates poverty and hunger, as people have no access to food, health care or housing, nor can they invest in the education of their children or their own economic initiative.

Climate change and poverty are interlinked. You cannot work effectively to reduce poverty while ignoring the effect of climate change on agriculture, the spread of disease and extreme weather events, factors with a strong impact in less developed countries.

The design of the MDGs recognizes that people's fate and environmental changes are interlinked. The world's poorest countries are dependent on agriculture and therefore are vulnerable to environmental degradation, while environmental damage such as water pollution, pose serious challenges to public health.

Predictably, the global economic crisis had repercussions on Angola. The pace of GDP growth declined in 2008 compared with the average during the previous decade and the effects of the crisis were even more severe in 2009, significantly affecting economic growth, employment and income. Nevertheless, per capita GDP was six

times higher in 2009 than that 2002. In 2009 per capita income was calculated at $3,900.

Oil and diamond extraction activities were also impacted by the global economic crisis, yet the non-oil GDP growth maintained the upward trend of the pre-crisis period, overtaking the expansion of oil GDP.

The non-oil sector increased its importance in the economy between 2008 and 2009 as agriculture (8.5% to 10.6%), manufacturing (6% to 7%) and public works (from 6.6% to 8%) all grew significantly.

The poor performance of the oil sector had a negative effect on the current trade balance and the tax variables (State Budget), which in turn affected the achievement of the MDGs.

The current balance of payments account was adversely affected in 2008 and 2009, with a balance of -6.7 billion dollars, due to a significant decrease in the surplus in the balance of goods (18.3 billion U.S. dollars in 2009, compared with 42,900 million in 2008) and a negative balance in services (17.9 billion U.S. dollars) and the income balance (7.1 billion U.S. dollars).

Therefore, 2009 saw the introduction of adjustments in the national plans. The adjustments occurred in terms of objectives, policies and intervention measures. The Public Investment Programme had to be revised in order to adjust its figures to available financial resources and the same happened with the State budget.

Overall, these changes reflected on the economy's capacity to provide jobs, with effects on the fabric of society, the social welfare systems, and on budget deficits.

International aid also decreased, which had repercussions on Angola's MDG targets through restricted public spending and non-governmental organizations that were traditionally supported by funds from abroad.

Climate change and the Millennium Development Goals

Climate change also created challenges for development and social equality, exacerbating stress factors that contribute to poverty.

When disasters occur, climate, food security and agricultural activities are often compromised, causing unemployment, food shortages, famine and massive short-term internal migration.

Public health also suffers from poor communication among services, poor housing and access to water, in addition to the other factors given above.

The most frequent weather events in Angola are related to rainfall and rivers bursting their banks, especially in the provinces of Huila and Cunene, displacing a large number of people due to disasters every year. These southern provinces, together with Namibe, comprise 40% of Angola's total population living in poverty. The high-seas that hit Luanda Island also caused the displacement of many families.

Education, an issue with a great impact on poverty, and public health are also affected by climatic accidents. Classes can be interrupted, affecting the efficiency of the teaching each year and hindering the advancement of universal primary education.

The main attributing factors are the difficulties to get around the cities and the countryside; the destruction of schools; the loss of means of subsistence (increasing the need for children to help in earning some income); and temporary displacement and/or family migrations.

The negative effects can have a more direct effect on women, with more work to do, new restrictions on the time to participate in making household decisions and in activities to generate subsistence income.

The United Nations 2008 document "C*limate change and MDGs*" recognises these effects and their greater impact on poorer economies, particularly in tropical and subtropical areas. According to the report, there is a trend towards increased frequency and intensity of extreme weather events.

The document also notes that poor countries lack the infrastructures needed to deal with the impact of these phenomena, such as storm barriers, water storage structures, for example. It recommends integrating environmental concerns into development plans, and the implementation of policies, laws and governance practices to protect the environment and especially to protect poor communities that are highly dependent on natural resources.

Developed countries and multilateral organizations should therefore help poor countries develop greater capacity to mitigate the effects of climatic accidents as part of their commitments to the MDGs.

3. MILLENNIUM DEVELOPMENT GOALS

GOAL 1: TO ERADICATE EXTREME POVERTY AND HUNGER

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Goal 1a: **To reduce the percentage of the population with an income of less than a dollar a day by half between 1990 and 2015.**

Goal 1b: To arrange full, productive work for everyone, including youth and women.

Goal 1c: To reduce the percentage of the population affected by hunger by half between 1990 and 2015.

Poverty and hunger remain to be social scourges in most of the world and ethical and moral problems as well as major obstacles to progress; they are the cause and effect of underdevelopment.

Illiteracy, poor health, low economic productivity, inadequate access to essential goods, and other factors, form a web of interrelated limitations that are imposed on poor people living in precarious conditions, depriving them of the opportunities offered by contemporary societies.

There is therefore a need for concerted action, planned by the State, in cooperation with other sectors of society to combat these hardships for humanitarian and economic reasons.

Eradicating extreme poverty and hunger is, within the strategic logic of the MDGs, the first objective of these three goals, measured by the following indicators: percentage of the population earning less than $1per day, level of overall employment/ unemployment, employment/unemployment by age and gender, and the percentage of people suffering from hunger.

A) DIAGNOSIS AND TRENDS

Data from 2009 on the goal to reduce poverty in Angola shows significant progress, according to results of the Integrated Population Welfare Survey (IBEP 2008-09), presented by the National Statistics Institute (INE).

The proportion of people earning less than $1 per day fell from 68% in 2001 to 36.6% in 2009, which is almost 93% of the desired value for 2015 – the target being 34% (Table 2).

Although this indicator is good news, there are still major internal disparities in the country with respect to poverty. According to IBEP, the proportion of poor in urban areas in 2009 was 18.7%, almost half the national share, while the rural poor accounted for 58.3%. In other words, for every 100 rural inhabitants, 58 are live on less than $1 a day, while in urban areas the ratio is 19 to 100.

This data shows that the incidence of poverty in rural areas is more than three times that of urban environments and 71% higher than the overall target set for 2015. The very poor are therefore concentrated in rural areas. Therefore the fight against poverty must be intensified in these areas, without slowing down ongoing activities in urban centres.

Table 2 – Poverty Indicators (2001; 2008/09; 2015)

Indicators	**2001**	**2008/09**	**2015**
Population under the poverty line (%)	68	36.6	34
Urban area (%)	…	18,7	
Rural area (%)	…	58.3	

Source: IBEP (2008-2009)

Disparities in poverty are also revealed when assessing regional figures. There are three areas that deserve greater emphasis in public policy to combat poverty: Cabinda, Uige and Zaire in the north, where the proportion of poor is almost four times the number of poor in the total population of the country, Lunda Norte, Lunda Sul, Moxico and Kuando east, where this ratio is 3.6, and Namibe, Cunene and Huila in the centre, which have a ratio of 2.5 (Table 3).

Table 3 - Poverty index by region (2008-2009)

Regions	**Poverty incidence (1)**	**Proportion of poor in total population (2)**	**Proportionality coefficient (3=1/2)**
1. Huambo, Bié, Benguela and Kwanza Sul	55	44	1.3
2. Lunda Norte, Lunda Sul, Moxico and Kuando Kubango	51	14	3.6
3. Luanda, Bengo, Malange and Kwanza Norte	17	17	1.0
4. Namibe, Cunene and Huíla	40	16	2.5
5. Cabinda, Uíge and Zaire	34	9	3.8

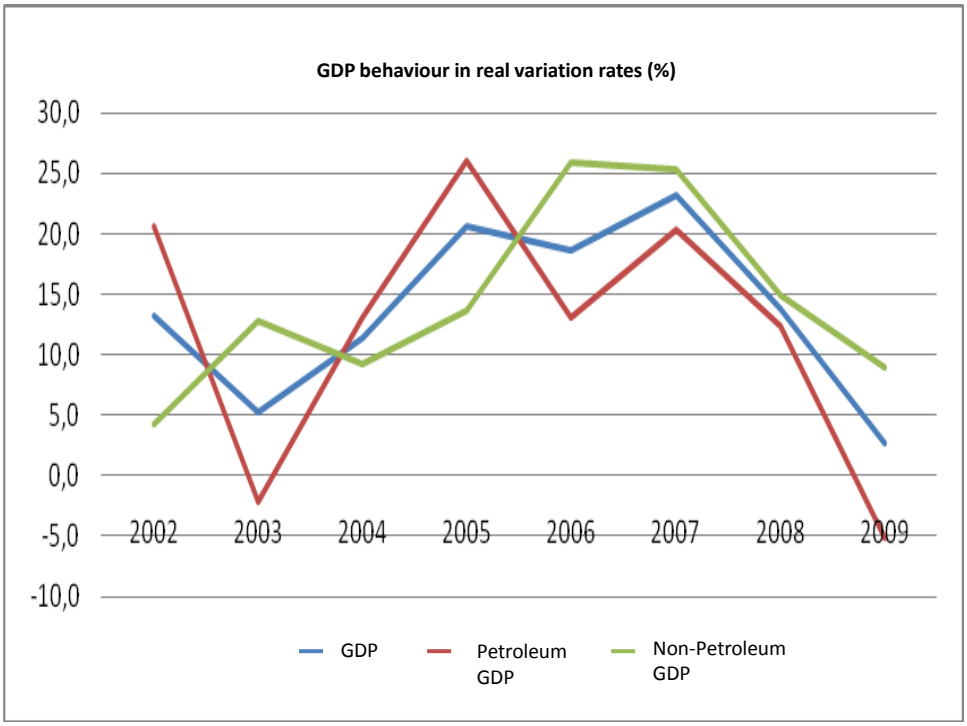
Source: IBEP (2008-2009)

These numbers reflect factors that contribute to poverty, mostly measured by other MDG indicators. Two of these factors are analysed in this part of the report, because of their close relationship with poverty- the economic growth rate and the of employment/unemployment rate.

Regarding the first, the empirical economic studies have shown that economic growth reduces the number of people below the poverty line. So as long as there is economic

growth, this relationship enhances the performance of the country's goal to poverty reduction.

In this respect, the analysis of the growth statistics indicate that between 2002 and 2007, the country showed an upward trend in GDP growth rate (except 2003) and an average annual rate of 14.6% in the same period.



Source: Ministry of Planning

Figure 1 – GDP behaviour in real variation rates (2002 - 2009)

From 2008 onwards, with the effects of international crisis, this behaviour has changed, causing the annual growth rate, which was 13.4% that year, to fall to 2.7% in 2009, the year the economy revealed the full impact of the crisis.

The structural changes that occurred in the economy since 2002 (Figures 2 and 3), including the period of crisis, may have contributed to mitigating the effects of economic instability on poverty.

Since 2002 and particularly since 2005, the non-oil sector has begun to show more dynamism than the oil sector. The typical non-oil sector activities have therefore become more important in the composition of Angolan GDP: 2002 to 2009 the share of agriculture in GDP grew from 8 to 11%, services 14 to 22% and construction 3 to 8%.

Note that these economic activities are more evenly distributed geographically and tend to be more labour-intensive than oil.

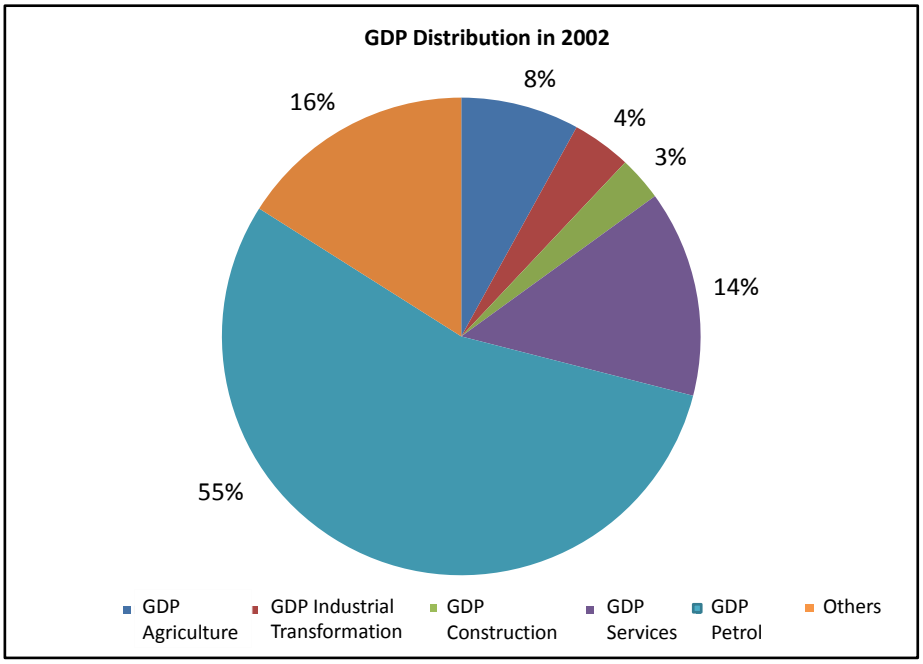


Figure 2 - Breakdown of GDP in 2002

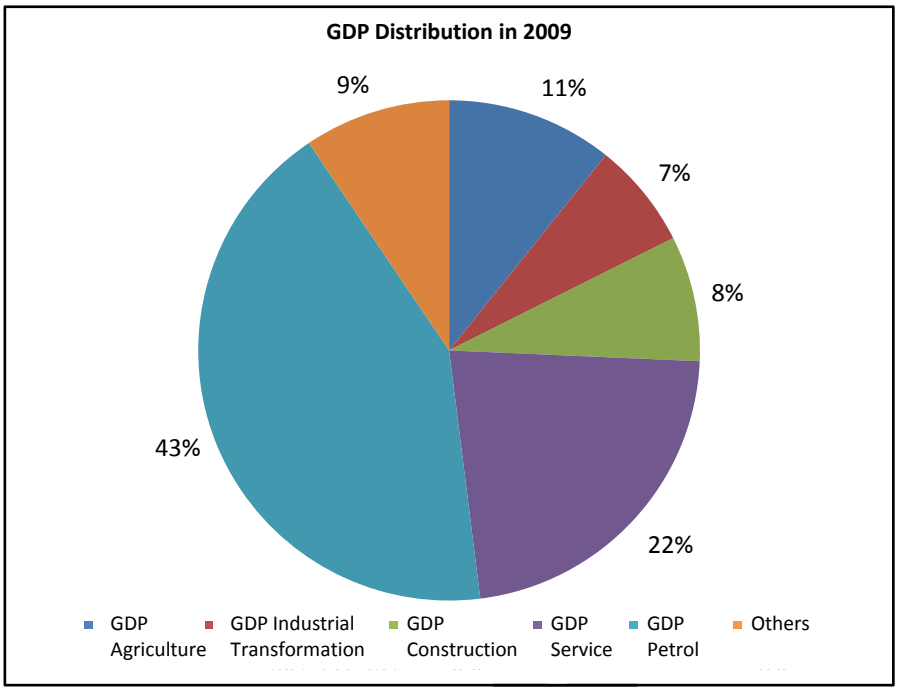


Figure 3 - Breakdown of GDP in 2009

The favourable economic scenario can also be confirmed by GDP behaviour of per capita, which grew steadily from 2001 to 2008, only dropping in 2009 due to the effects of the international crisis in Angola. Still, the GDP per capita in 2009 (USD 3,900) was six times the figure recorded in 2001.

Table 4 - Behaviour of GDP *per capita* (2001-2009)
(Amounts in USD)

Variable	2001	2005	2006	2007	2008	2009
GDP *per capita*	643.1	1984.8	2565.6	3487.1	4707.4	3900

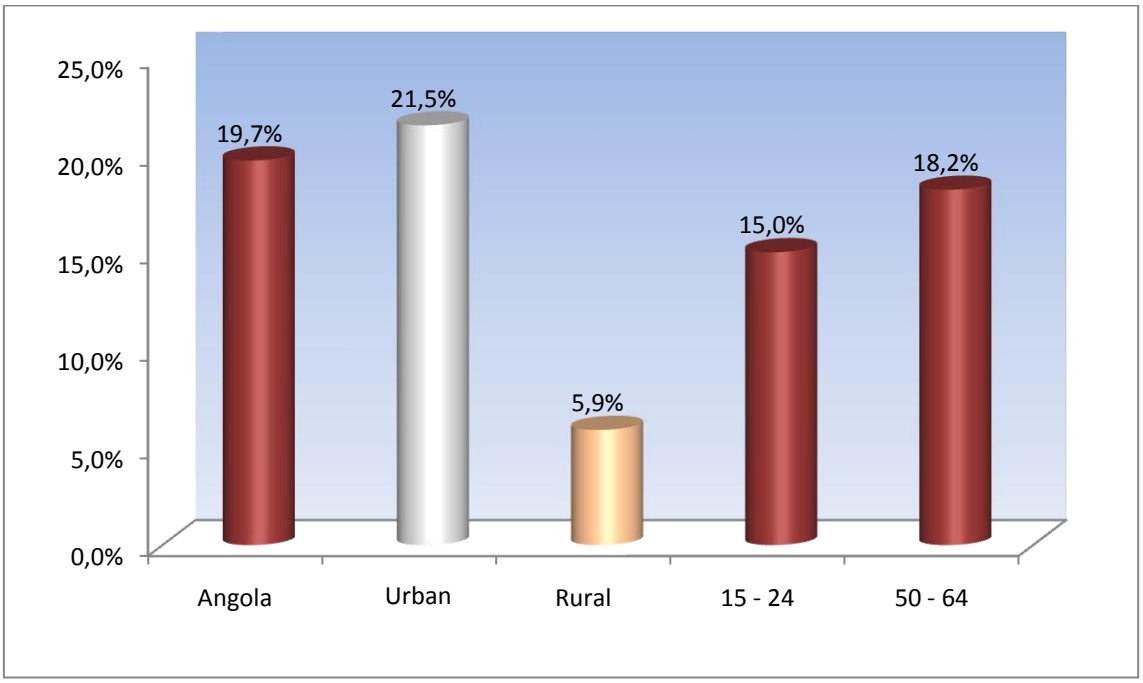
Source: Ministry of Planning

Economic growth and the changing composition of the country's GDP towards activities that employ more people such as construction, services and agriculture, certainly led to an expansion of employment in the period between 2000 to 2008.

The correlation between employment and growth is demonstrated in economic studies, although the sensitivity to changes in the employment growth rate depends on the type of economic activity in expansion, given the differences in technology and manpower productivity.

Alterations have also been seen in Angola's formal economy, along with a growth of informal sector activities, including self-employment, informal trade and micro and small garment services.

Although no official unemployment statistics are available from the Labour Force Survey in Angola (IEA), IBEP data (2008-2009) indicate that about 20% of the population aged 15 to 64 were unemployed in 2009.



Source: IBEP (2008-2009)

Figure 4 – Percentage of the population between 15 and 64 that is unemployed and looking for a job for more than 12 months, according to zones and age groups (2008-2009)

The proportion of the unemployed shows great differences across the country and between genders and age groups (Figure 4). The significant difference between urban

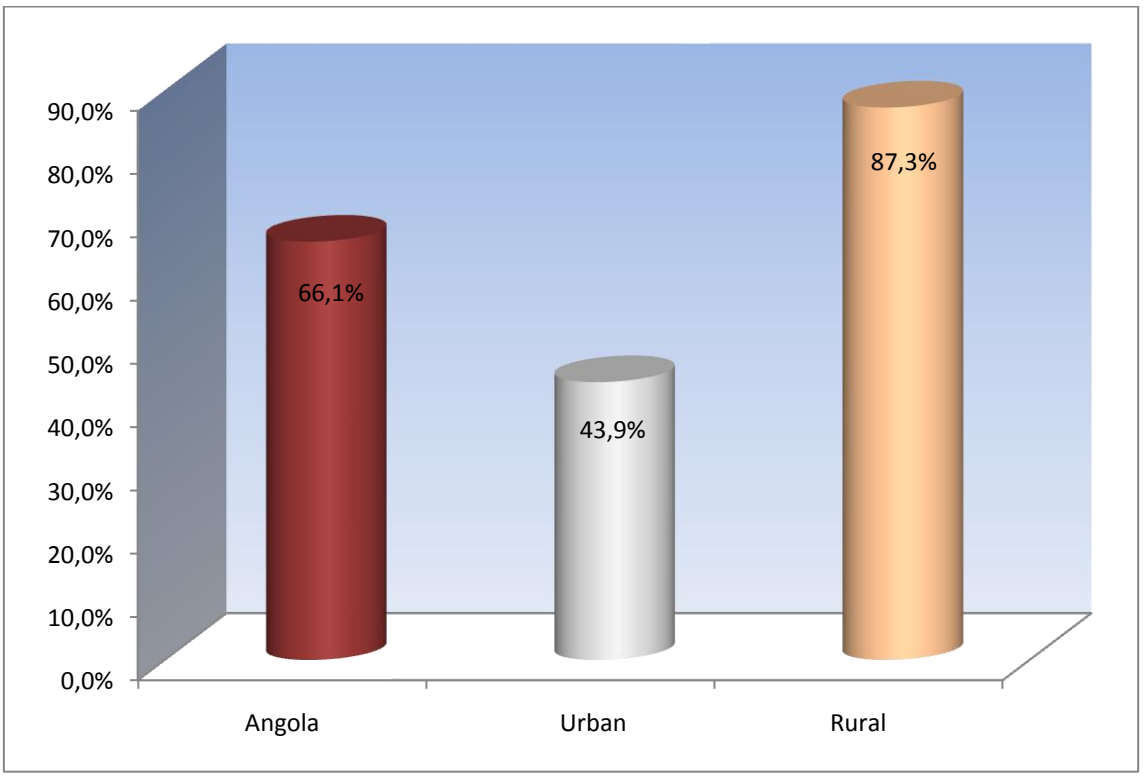
and rural unemployment can be explained by employment on family farms. Gender differences can be explained by differences that still exist in education and training opportunities.

While there are no statistics to analyse the progress in reducing these disparities, it is possible to infer that these figures reflect the attenuation of even greater disparities in the past, considering that significant investments were made in the context of the integrated rural development program in the period of 2002-2008. There was a revival of agricultural activities, greater financial assistance for farmers and small business owners and educational opportunities for women and young people were expanded.

Figure 5 shows another relevant labour market phenomenon in Angola: the importance of self-employment. According to IBEP data from 2008-2009, the self-employed and unpaid family workers accounted for 66% of everyone in a job.

The frequency of this type of occupation is significantly higher in rural areas, where 87 out of 100 employees are self-employed or unpaid family workers. This confirms the argument presented earlier to explain the occurrence of rural unemployment at almost a third of the urban rate.

Furthermore, as expected, the data also reveal that self-employment and family employment is even more prevalent in women and older workers.



Source: IBEP (2008-2009)

Figure 5 – Percentage of self-employed and unpaid family workers out of the total work force (2008-2009)

In regard to hunger, and sorting the data on the incidence of poverty, according to Ministry of Health data 52% of Angolans ate fewer than 3 meals the day before the survey, with significant differences between urban and rural populations (Table 5).

Table 5 – Percentage of people who ate fewer than 3 meals the day before the survey (2007)

Regions	Percentage
Angola	51.8
- Urban area	36.6
- Rural area	70.9

Source: Ministry of Health, Report of the survey into nutrition in Angola (2007)

Table 6 presents information on the very positive developments in the nutritional status of children aged under-five, a very important hunger indicator. According to INE, there was a drop in the number of children in this age group who are below average weight and have lower than recommended height for their age.

There is, however, a deterioration in the "weight for height" indicator (two or more, or three or more standard deviations below the mean), leading to infantile atrophy, which contrasts with the favourable nutritional situation revealed by the other two indicators. Health authorities should pay more attention to the infantile atrophy indicator, taking into account that the roots of extreme infantile atrophy, revealed by three or more standard deviations below the mean, are often chronic malnutrition, typical of populations in extreme poverty.

Table 6 – Indicators of the nutritional state of children under 5 years old (percentage)

Indicators	2 or more standard deviations below the average		3 or more standard deviations below the average	
	2001	**2007**	**2001**	**2007**
Weight for the age (low weight)	30.5	15.6	8.4	6.6
Height for the age (Dwarfism)	45.2	29.2	22.1	12.2
Weight to height (infantile atrophy)	6.3	8.2	1.1	4.3

Sources: INE, Multiple Indicator Survey – MICS (2002 and 2007)

Generally, regional gender differences regarding the values of these indicators decreased from 2001 to 2007. There was, however, an increase in infantile atrophy from 5.8 to 8.1% in rural areas, against a much smaller increase in urban areas (Table 7).

Table 7 – Indicators of the nutritional state of children under 5 years old by region

Indicators	Height/Age		Weight/height	
	2001	2007	2001	2007
Angola	45.2	29.2	6.3	8.2
Place of residence				
Urban	43.3	30.1	6.5	6.9
Rural	49.6	33.0	5.8	8.1

Sources: Multiple indicator Survey (MICS), 2002; Ministry of Health, Report on the Nutrition Survey in Angola, 2007.

B) CHALLENGES

Poverty remains a major challenge for the Angolan government and society in general. In this context, an additional difficulty to overcome is the fight against this phenomenon in rural areas, given the large asymmetries observed for the urban environment, and at least two administrative regions of the country, which have a disproportionate concentration of poor people.

Hunger and malnutrition remain critical problems arising from poverty, which require well-focused action and must be treated as an urgent, top priority.

The measurement of the phenomenon and its causes should be considered a challenge that is as important as the effective implementation of the policy already outlined to combat poverty, as it contributes to the effectiveness of the policy and thus enhances its positive impact on the poor.

Finally, the critical nature of poverty and hunger means multidisciplinary and multi-sectoral difficulties must be overcome, requiring that consultation and cooperation mechanisms between government bodies must work properly, partnerships must be formed with civil society and international organizations, and there must be a constant state of evaluation on how effective the actions are.

C) POLICIES AND PROGRAMMES

As a consequence of the results and complexity of the phenomenon, the Government revised its strategies to combat poverty and hunger in 2009 by providing a country-wide programme to combat these issues, as a way of increasing the emphasis on existing actions and strengthening the joint work of the Ministerial Departments and Provincial Governments.

The Integrated Program to Combat Poverty and Rural Development is one of the main instruments of the National Action Plan 2010-2011 (Figure 6). The program is an essential part of the government intervention, designed to provide national solutions to three highly complex, interrelated problems, which have a major impact on the quality of life and national development: poverty, malnutrition and low agricultural production and productivity.

The programme is based on the priority areas of the Strategy to Combat Poverty and the National Food Security Strategy recommendations.

The program consists of six main areas, divided into actions to be run by the ministerial departments responsible for their sectors, and also includes a series of performance indicators to enable evaluation and follow-up actions.

Figure 6 – Integrated programme Model to Combat Poverty and Rural Development

Many other actions that the Government carried-out also contribute towards combating poverty and hunger, such as job and income creation, increased production, productivity and diversification of agriculture, expanding the availability of drinking water and sanitation, expanding education and combating diseases.

GOAL 2: ATTAIN UNIVERSAL PRIMARY EDUCATION

Objective 3 - TO GUARANTEE THAT ALL BOYS AND GIRLS FINISH THEIR PRIMARY EDUCATION

GOAL 2: ATTAIN UNIVERSAL PRIMARY EDUCATION

Objective 3 - To guarantee that all boys and girls finish their primary education

Education is an important factor in human development, sustainable development, wider horizons and self-esteem. As a result, massive continuous investment in education has been a public policy priority throughout the world. It is one thing that academics, policy-makers, politicians and governments around the world all agree upon.

Universal access to quality primary education, without gender differences, is the third of the Millennium Development Goals.

This aspiration is measured by three indicators: net enrolment rate in primary schools, percentage of pupils starting grade 1 and reaching grade 5 and the literacy rate in 15 to 24-year-olds.

A) DIAGNOSIS AND TRENDS

The number of pupils enrolled in primary education in Angola rose from 1,296,560 in 2001, to 3,967,886 in 2009, an increase of some 206% over the period.

Table 8 – Indicators of the Size of the Education System (2001-2009)

Indicators	2001 (1)	2009 (2)	Variation over the period 3=(2/1)%
Total (No. of pupils enrolled)	1,296,560	3,967,886	206
Enrolment rate for children 7-17 years old	N/A	79.5	-
- Urban (Percentage of total)	N/A	85.5	-
- Rural (Percentage of total)	N/A	72.2	-
Net rate of primary school enrolment	N/A	77.2	-
- Urban (Percentage of total)	N/A	85.6	-
- Rural (Percentage of total)	N/A	68.5	-

(*) proportion of 6 to 11 year-old children who attend primary education
Source: Angolan Ministry of Education

Almost 80% of children and adolescents aged between 7 and 17 were enrolled in school in 2008-2009. In that academic year, the net attendance rate stood at levels approaching (77.2%) following a constant increase since 2000 (that year, the percentage was 38.2%).

Similarly to what occurred in regard to poverty and hunger, the growth in enrolments was different in rural and urban areas of the country.

Primary school enrolment rates and net frequency in rural areas were 72.2% and 68.5% respectively, which were 80.0% and 83.5% of the corresponding indicators in cities in 2009.

These differences may be explained, among other factors, by the need for children to participate in efforts to supplement the family income, the greater or lesser distance between the school and home, lack of revenue for additional private costs to free education, the level of education and the priority given by these students to access education.

IBEP Data (2005-2006) revealed that the need to work and to pay tuition fees account for almost two thirds of the reasons for not attending school.

Despite the constraints mentioned above, it is important to recognize the progress the education system has made with respect to the expansion of its capabilities, thanks to an investment program focused on the rehabilitating and building of new schools, hiring and training of teachers, purchasing of equipment and materials and the distribution of school meals.

However, the gains made in the progress of the system are lower than expected. The approval rate for primary school planned for 2015 was 80%, but after rising from an initial rate of 16% in 2000, this rate has remained level at 60% according to the Ministry of Education (Table 9).

A similar thing has been seen in school failure rates.

This indicator has been stationary at 20% for recent years.

If this performance does not improve, the 13.2% MDGs target is not expected to be met.

Table 9 – Education System Productivity Indicators (2000-2015)

Indicator	2000	2007	2008	2009	2015
Pass rate	16.0(1)	57.0(1)	60.0(1)	60.0(1)	80.0(1)
Repeat rate	26.3(2)	N/A	N/A	N/A	13.2
Drop-out rate	13.9(2)	20.0	20.0	20.0	6.9
Gross education rate	N/A	127.1	139.1	146.1	N/A

(1) Completion rate; (2) 2003 figures
Source: Ministry of Education

Moreover, there is the fact that education in Angola has also a significant number of students have been held back in earlier in academic years. This phenomenon is a disruptive factor in the system as revealed by the gross enrolment rate of more than 100, as shown in Table 9.

The difficulties seen by the Angolan education system are rooted in the number and training of the teachers and students' socio-economic conditions.

In regard to the first of these factors, a massive increase in the number of teachers in recent years should be acknowledged as shown in Table 10, where there were almost 110,000 teachers in 2009.

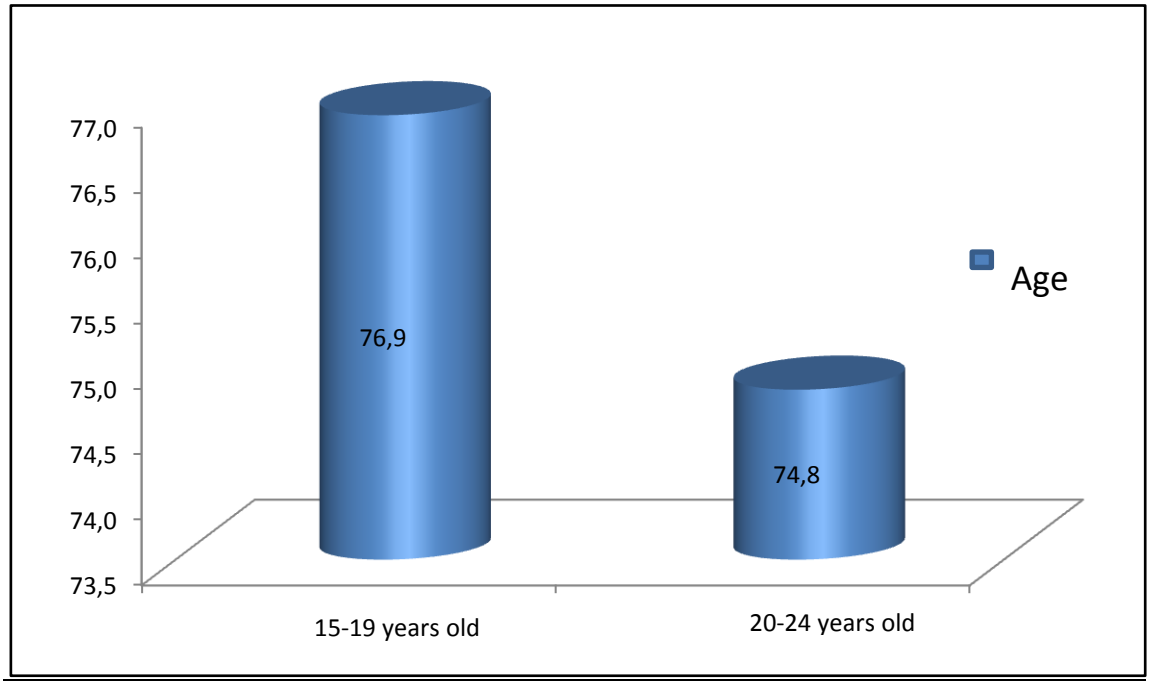
On the other hand, investments in expanding schools contributed to the reduction of the number of students in primary classrooms, despite the increased number of pupils who were enrolled, which has a positive impact on the quality of education.

Table 10 – Education System capacity Indicators (2007-2009)

Indicator	2007	2008	2009
No. of teachers	79,939	89,977	109,977
No. of primary classrooms	41,343	45,608	46,608
Ratio of pupils/primary classroom	119	114	99

Source: Ministry of Education

In terms of literacy in Angola, IBEP data (2008-2009) indicates an overall literacy rate of 76% in 2009. Figure 7 shows the differences in the literacy rate of between two age groups. IBEP Data (2008-2009) shows a literacy rate of 39.6% for people age 50 and over. This data indicates that illiteracy is higher the older the citizens.



Source: IBEP (2008-2009)

Figure 7 – Literacy rate in Angola for 15 to 24-year-olds

The difference between the urban and rural sectors, seen in the analysis of other indicators, also occurs in regards to literacy rates (Table 11). The rural literacy rate was 56.3%, which was 63.6% of the urban rate (88.5%), significantly lowering the national average rate (76.0 %).

Table 11 - Total literacy rate in Angola by area of residence and age (2001-2009)

Indicators	2001	2009
Literacy rate (population of 15-24) (%)		76.0
- Urban (Percentage of total)	N/A	88.5
- Rural (Percentage of total)	N/A	56.3

Source: Angolan Ministry of Education

B) CHALLENGES

Although there are still gaps in the education system, particularly in rural areas, the diagnosis shows that the greatest constraint on the system is in the field of productivity, there is a need to improve completion, failure, abandonment and the number of students that are held back which are higher than recommended.

In addition to continued investments in expanding capacity, the removal of obstacles to improving the quality of education requires: the commitment of additional budgetary resources, books and educational materials, hiring and training of teachers, implementing new teaching methods, stronger institutions, planning, management and performance evaluation.

International financing, cooperation and technical and educational exchange, focusing on the obstacles to be removed and the needs to expand and improve the quality of education, would be necessary to fulfil these needs.

C) POLICIES AND PROGRAMMES

The government has made a great effort to implement actions to improve education, such as:

a) Introduction of national languages in the education system, seeking to overcome dialogue difficulties between teachers and students, due to lack of the necessary linguistic skills in the language of schooling - Portuguese - by children or adults, in early learning;

b) Implementation of the Child Friendly School Programme which, with support from UNICEF and parents' and guardians' associations has, among other things, helped to change the climate of aggression and lack of respect for the rights of children in many educational institutions, thus creating an environment that fosters well being and a better quality of education within the school community;

c) Design of educational policies that result from extensive consultation of other stakeholders (trade unions, teachers associations, parents' and guardians' associations, academics) and representatives from international agencies (UNICEF, UNESCO, UNDP);

d) Identification, training and recruitment of education assistants and teachers to handle the growing number of pupils;

e) Resolution of cross-sector issues beyond the competence of each Ministerial Department, through the 2010-2011 Biennial Plan of the National Council of Children, where the "11 Commitments to Children" included schooling;

f) Curricula that focus on basic learning and the use of primary teaching manuals produced as part of the educational reform to improve pupils' knowledge and the quality of the teaching;

g) Refurbishment and construction of physical infrastructures;

h) Availability of enough school materials.

GOAL 3: PROMOTE GENDER EQUALITY AND WOMEN'S SELF-HELP

OBJECTIVE 4 - TO ELIMINATE THE GENDER GAP IN PRIMARY AND SECONDARY EDUCATION IF POSSIBLE BY 2005 AND IN ALL LEVELS OF EDUCATION BY 2015

GOAL 3: PROMOTE GENDER EQUALITY AND WOMEN'S SELF-HELP

Objective 4 - To eliminate the gender gap in primary and secondary education if possible by 2005 and in all levels of education by 2015

Differences in opportunities are, nowadays, an important sign of the status of a particular country or region, and are an essential indicator of human development.

This question is addressed in the third Millennium Development Goal and is measured by the fourth objective and the indicators for gender differences in education, literacy, employment in the non-agricultural sector and representation in parliament.

A) DIAGNOSIS AND TRENDS

2009 saw a continuation of the gender balance noted in 2005, regarding the proportion of boys and girls who attended primary and secondary school.

It is noteworthy to state that there were no significant gender differences regarding the national net rate of school attendance, according to data included in Table 12.

Table 12 - Gender Inequality Index and Net Tax Rate for Education in Angola (2008-2009), according to level of education and gender

Gender	Primary education	Secondary education
Boys	77.2	20.6
Girls	75.4	17.4
Total	77.2	20.6
Gender inequality index	0.98	0.85

Source: IBEP (2008-2009)

Analysing the Gender Inequality Index, it was clear that there was no gender gap at the primary level and the differences were insignificant at the secondary level (Table 12).

In combining two factors - gender and area of residence - the differences in primary education still did not appear, but the number of girls in secondary education in rural areas is becoming notable - net attendance rate of girls in education secondary falls from 28.0% in urban areas to 1.8% in rural areas, according to IBEP data (2008-2009). For boys, the fall was from 31.7% to 6.6%.

At the provincial level, an analysis of gender equality in terms of the net rate of primary and secondary education can be made with the help of Table 13, where the provinces are broken down into four parity groups.

The worst performance in terms of the secondary school parity index becomes clear: 56% of provinces had a parity index below 60%, and most were below 50%.

In primary education, the behaviour was practically the opposite, since 94% of provinces had a parity index of 80 or over and no province had an index equal to or below 60%.

Table 13 - Ranking of provinces according to the Gender Parity Index in primary and secondary schools in Angola (2008-2009)

Index Parity Range Categories	Primary education		Secondary education	
	No./ (%)	Provinces and indicator values (%age)	No./ (%)	Provinces and indicator values (%age)
Equal to or greater than 100%	06 (33)	Zaire (103.1), Kwanza Norte (109.2), Benguela (101.4), Namibe (111.0), Huíla (107.1) and Cunene (104.5)	01 (6)	Cunene (109.7)
Equal to or greater than 80% and under 100%	11 (61)	Cabinda (95.2), Uíge (93.8), Luanda (99.7), Malange (99.6), Lunda Norte (88.9), Huambo (84.1), Bié (88.2), Moxico (88.1), Kuando Kubango (96.9), Lunda Sul (97.0) and Bengo (99.4)	06 (33)	Uíge (90.6), Benguela (87.3, Huambo (86.5), Namibe (80.1), Huíla (81.9) and Luanda (90.9)
Equal to or greater than 60% and under 80%	01 (6)	Kwanza Sul (75.5)	01 (6)	Cabinda (76.7)
Under 60%	00 (0)	-	10 (56)	Zaire (46.7), Kwanza Norte (48.5), Kwanza Sul (45.0), Lunda Norte (56.7), Bié (34.2), Moxico (20.7), Kuando Kubango (37.0), Lunda Sul (49.3) and Bengo (37.4)
TOTAL	18		18	

Note: Index calculated using net enrolment rates
Source: IBEP (2008-2009)

There were two indicators regarding literacy - the literacy gender parity index and the proportion of women aged 15-24 who could read and write.

In regard to the first indicator, the figures in Table 14 show that the parity index ranges from 27.4% for the age group of 50 or more to 84.4% for 15 to 19-year-olds.

No statistics were available that associate gender and area of residence, but following the national literacy rate, which showed significant differences between rural (56.3%) and urban (88.5%), we inferred that the disparities between men and women were much greater in rural areas.

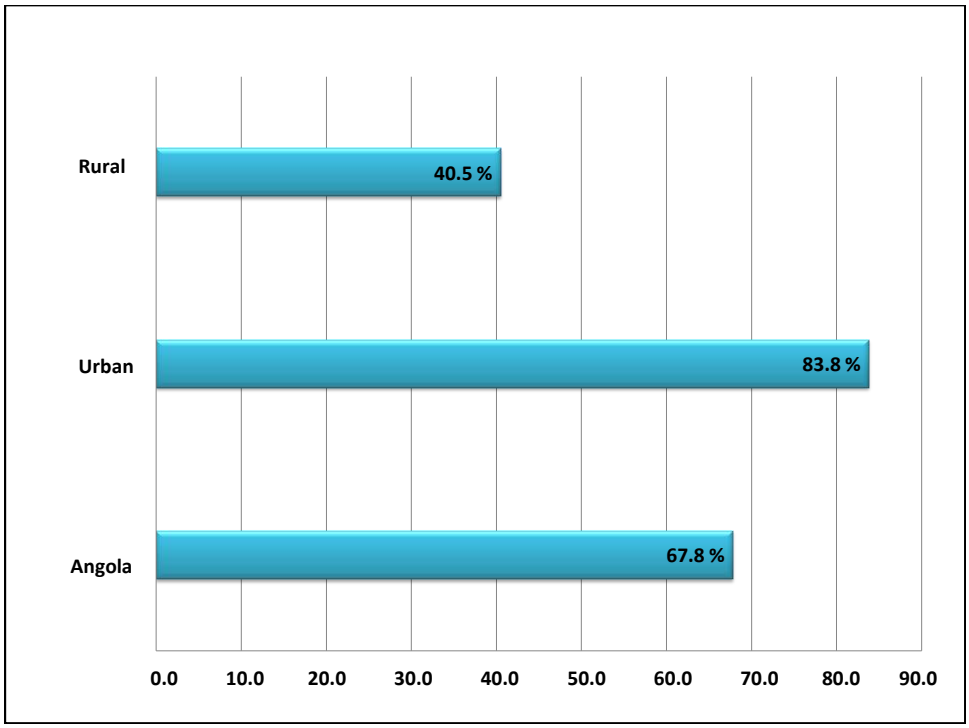
Table 14 - Literacy Gender Parity Index by age group (2008-2009)

Age group (years of age)	Index (%age)
15-19	84.4
20-24	73.8
25-29	64.9

30-34	63.0
35-39	60.7
40-44	59.5
45-49	51.2
>50	27.4

Source: IBEP (2008-2009)

67.8% of women aged 15 to 24 could read and write although this rate differs significantly when the area of residence was taken into consideration. Only 40.5% of rural women were literate, compared with 83.8% of urban women (Figure 8).



Source: IBEP (2008-2009)

Figure 8 - Proportion of women aged 15-24 who can read and write (national, rural and urban) (data 2008-2009)

In terms of employment, it was found that in 2008-2009, 43.2% of women between 15 and 64 years had non-agricultural employment, decreasing in older age groups.

The participation of women in public life in Angola in parties represented in parliament (MPLA, UNITA, PRS, FNLA and Nova Democracia) it appeared that the ruling MPLA party reserved 81 seats for women in its party out a total of 191 seats in the 2008 legislature which corresponds to 42.4% of parliamentary seats allocated to women.

On the other hand, UNITA, the largest opposition party set aside four seats for women out of 12 MPs, which is a 33%. The other minority opposition parties had no women in their parliamentary groups.

Out of the 220 seats in the parliament, 85 of them, or 36% of the total, were occupied by women.

Women had 26% of the cabinet seats nationally: 11% were ministers, 8% deputy ministers and 5% secretaries of state. In the ministerial departments, the relationship between men and women was 71% men to 29% of women, in deputy ministers, 81% men to 19% of women and, in Secretaries of State 78% men to 22% women.

Woman held the following posts in the Attorney General's Office in 2009: 8.9% of the posts reserved for municipal prosecutors, 36.3% of which were set aside for deputy provincial prosecutors, and 12% of which were for deputy attorney generals. In the Constitutional Court, women accounted for: 33.3% of advisers, 50% of section heads, 66.7% of department heads, and 42.9% counsellor judges, only in the four seats for directors were there no women. Finally, in the Supreme Court, the women held: 75% of the division heads, 50% of department heads, 33.3% of retired judges, and 16.7% counsellor judges, and were only not represented as section chiefs or as vice president.

The increased participation of women in state decision-making bodies arose from a decision by the country's president, who initially proposed 30% female representation in parliamentary seats for his party and 30% in central government posts. As a result of this policy today, "Angola is the tenth country with the highest participation of women in decision making."[3]

B) CHALLENGES

Based on the indicators that were analysed, particularly those relating to primary and secondary education, literacy and non-agricultural employment, it is possible to conclude that there are major challenges in secondary education, completion rates in primary and secondary education, literacy rates and non-agricultural employment. Furthermore, the differences that were seen became more marked in rural areas and in older age groups.

The reduction of these differences and effectiveness of public policies are hampered by stereotypes, which become confused with the African tradition that place women at a disadvantage relative to men.

There is also a need for a greater understanding of gender issues in the context of the cultural reality of different ethno-linguistic groups on gender-differentiated practices that are known to exist but are not sufficiently documented, analysed or disseminated, especially in the economic, labour and political domains.

Broadly speaking, we can say that the key challenges to be considered for achieving gender equality are:

[3] See, Cesaltina Major,President of the Angolan Network of Women Parliamentarians in the 122nd Meeting of the Inter-Parliamentary Union, held in Bangkok, cit. in Angola Taishikan News (29 June 2010), Official Publication of the Diplomatic Mission of the Republic of Angola in Japan, Tokyo, s / t; Also on http://www.portalangop.co.ao/motix/pt_pt/noticias/politica/2010/4/21/Participacao-mulheres-orgaos-decisao-destacada-por-publicacao,8ff3493d-bec4-4f87-8551-5e32ab0078f6.html

a) To sustain and ensure the operation of existing policies leading to a reduction of gender inequality related to education and areas of residence;

b) To intensify education for mutual respect and effective equality in the relationship between men and women, taking into account the cultural specificities of the country;

c) To promote academic research to obtain a better understanding of the issues that are relevant to progress in gender equality and that empower women.

To meet these challenges, it is essential to ensure interaction between the various government departments involved in achieving an objective and clear definition of programmes, and projects along with indicators associated with the programmes and projects, to facilitate the assessment of progress.

C) POLICIES AND PROGRAMMES

The Government has made gender and women's empowerment an important part of the national agenda for public policies, with broad implications for government decisions and full citizenship. A strategy on gender was designed as part of this effort to increase women's participation in positions of responsibility in the social, economic, political and family domains, respecting the principles of equality, development and peace.

The Action Plan on Education for All (School for All, 2001-2015) is of particular importance as the Government is committed to improving and ensuring access, permanence, learning quality and full participation of all Angolans in basic education, to eliminate disparities between boys and girls.

The main objective is to increase women's places in positions of responsibility in different socio-economic areas; the state will continue to strengthen agreements with bilateral and multilateral organizations such as UNDP, UNIFEM, UNICEF and UNFPA for assistance in areas considered as a top priority for the Ministry of Family and Women's Promotion.

GOAL 4: REDUCE INFANT MORTALITY

OBJECTIVE 5- TO REDUCE THE MORTALITY RATE OF CHILDREN UNDER FIVE BY TWO-THIRDS BETWEEN 1990 AND 2015

GOAL 4: REDUCE INFANT MORTALITY

Objective 5- To reduce the mortality rate of children under five by two-thirds between 1990 and 2015

Infant mortality is a multidimensional phenomenon impacted by a number of interrelated factors like the socio-economic conditions of families, maternal care and child nutrition, childhood vaccination, the schooling and access to information, particularly mothers, and environmental and sanitary conditions, among others.

The complexity of the phenomenon and its strong correlation with poverty and people's income levels make the infant and child mortality rate an essential indicator of the compound development indices.

Infant mortality rate is the fourth MDG.

The target is to reduce it by two thirds for children under-five years of age by 2015. Other indicators include the infant mortality rate (children between 0 and 12 months) and the percentage of children under one year old immunized against measles.

A) DIAGNOSIS AND TRENDS

According to the IBEP (2008-2009), the mortality rate of children under five was 193.5 per 1000 children in 2009 (Table 15). This result suggests significant progress in relation to the 2001 numbers (250/1000), but the effort must continue to ensure reaching the target of 104 per 1000 children in 2015.

Although still high by international standards, this rate has allowed Angola to no longer be considered as one of the countries with the worst infant mortality rates in the world and has joined the group of countries with moderate rates.

Table 15 – Mortality rates for children under 5 years of age (2001-2015)

Years	Rate (Number of deaths per 1,000 children)		
	Total	Urban	Rural
2001	250.0	N/A	N/A
2009	193.5	154.3	233.0
2015	104.0	-	-

Sources: MICS 2 (2005); IBEP (2008-2009)

Besides the care associated with maternal and reproductive health, there is a need for improvements in pregnancy monitoring, including the prenatal, maternal and child nutrition and immunization coverage.

Other factors have also contributed significantly to the progressive improvement regarding infant and child mortality such as: advances in health care, greater access to

clean water, more access to information about health care, less illiteracy and the greater education for parents and mothers in particular. This combination of factors contributes to fight diseases and improve the general health of families, mothers and children, and consequently to reduce the rate of infant and child mortality.

The infant mortality rate (children from 0-12 months) was lower (116 children per 1000 live births) than that of children aged 0-4 years (195 per 1000 live births), as shown in Table 16, and that of 0-5 year-olds (Table 15). However, it was still higher than the target set for the infant and child mortality rate for 2015.

Table 16 - Infant and Child Mortality Rate in Angola, according to area of residence, gender and mother's education (2008-2009)

Categories	Child mortality rate 0-12 months old	Child mortality rate 0-4 years old
Angola		
Place of residence		
- Urban	93	150
- Rural	141	238
Gender		
- Boys	124	203
- Girls	108	187
Mother's schooling		
- None	133	224
- Primary education	119	200
- Secondary education or more	75	118
- Other or not declared	92	149

Source: IBEP (2008-2009)

More children died in rural areas and most victims were male children, whose mothers had a low level of schooling. The huge difference between the values of this indicator between urban and rural environments can be explained by factors such as poor access to essential health care, disease prevention, and poor handling of food and water.

These differences between rural and urban areas can also be considered as indicative of social exclusion in Angola, as children in rural areas, who are the poorest, are almost twice as likely to perish compared to those living in urban areas.

It is also noteworthy that the highest mortality rates are in the border provinces and the interior, and lowest in the capital and coastal areas of the country.

In terms of diseases that can be prevented, there was a reduction in the number of measles cases (a communicable disease that claimed the lives of countless children in 2003), due to the expansion of the vaccination programme that increased coverage. As a result, the ratio of the number of children immunized against measles increased from 53.4% in 2001 to 57.8% in 2008.

Table 17 - Proportion of Children Immunized against Measles (2001-2008/09)

Years	Percentage
2001	53.4
2008-2009	57.8

Sources: MICS 2 (2002); IBEP (2008-2009)

In regard to the place of residence, 74.3% of children under-one year of age were immunized in urban areas, compared to 38.4% in rural areas in 2009. This coverage is still limited compared to the 90% target for 2015.

There are no significant gender differences (parity index 91.5%), but is worthy to note the advance of vaccination coverage in children of mothers with a higher level of education. 38.8% of children whose mothers have no schooling coverage are vaccinated, while the children of mothers with secondary education have a coverage of more than twice that figure, 81.6% (Table 18).

Table 18 - Percentage of children one-year-old immunized against measles in Angola, according to the Gender Parity Index mother and child characteristics (2008-2009)

Categories	Percentage of children vaccinated
Angola	57.8
Place of residence	
- Urban	74.3
- Rural	38.4
Gender	
- Boys	60.5
- Girls	55.3
Gender parity index	91.5
Mother's schooling	
- None	38.8
- Primary education	58.0
- Secondary education or more	81.6
- Other or not declared	78.1

Source: IBEP (2008-2009)

The coverage rate of vaccinations against childhood diseases (BCG, DPT, polio and measles) in one-year-old children was 29.1% in 2008-2009, which was a small improvement over the 26.7% recorded in 2001. The differences in the area of residence are striking, while those of the gender are almost non-existent.

The most striking fact was, once again, the increase in coverage related to the mother's education. The vaccination rate among children with uneducated mothers was 13%, while the mothers of children with secondary level education or more was 51%.

Table 19 - Percentage of one-year-old children vaccinated with all childhood diseases vaccines (BCG, DPT, polio and measles) in Angola, according to child and mother characteristics

Categories	Percentage of children vaccinated
Angola	29.1
Place of residence	
- Urban	43.3
- Rural	12.4
Gender	
- Boys	29.3
- Girls	28.9
Mother's schooling	
- None	13
- Primary education	28.6
- Secondary education or more	51
- Other or not declared	42.4

Source: IBEP (2008-2009)

As for polio, the picture is more positive, since this disease has almost been eradicated in Angola. The improvement of this factor mainly has to do with intense campaigns as "kick polio out of Africa," which contributed greatly to reducing the prevalence of the disease and it's near eradication, as indicated by recent data.

Routine vaccination campaigns were conducted by stationary, mobile and advanced teams. Administrative data provided by the National Directorate of Public Health (DNSP) indicate the following national immunization coverage: Pentavalent-3, 73%; Polio-3, 73%, BCG, 83%, Measles, 77%, Tetanus, 77%, and yellow fever, 40%.

Six of the 18 provinces covered managed over 80%, 11 have covers between 50 and 79% and two reached 45% and 43%, according to the DNSP.

Comparing the results achieved in 2008-2009, the DNSP considers that coverage in the provinces of Benguela, Huila, Lunda Sul and Zaire fell compared to 2008, and that Bie province is still under performing. We note, however, the improvement of coverage in the province of Luanda.

B) CHALLENGES

Among the challenges that were identified to help eliminate constraints on achieving Objective 4, include: the need to continually increase the effort to vaccinate children living in rural areas, the improvement of access to clean water through the extension of the distribution network, to increase investments in collecting, cleaning and waste disposal and the elimination of stagnant water and improved sewerage and sanitation, the intensification of education campaigns for the use of locally grown foods that are

richer in vitamins and other nutrients in order to reduce the rate of malnourished children with chronic malnutrition, and increased access to the basic food basket.

C) POLICIES AND PROGRAMMES

The strategy to combat child mortality is described in the Strategic Plan for the Reduction of Infant Mortality and considers expending and improving the effectiveness of the current measures:

- Vaccination campaigns against measles, yellow fever, polio and vitamin A supply;
- Food Basket Program;
- Hand washing and oral hygiene campaign ;
- Awareness campaigns, through informative and educational material on: prevention of H1N1 flu; infant feeding from 6 months to 5 years, the importance of children aged 6 months to 5 years old taking vitamin A, and prevention of rabies and tetanus, and compliance with the vaccination schedule.

GOAL 5: IMPROVE MATERNAL HEALTH

OBJECTIVE 6- TO REDUCE MATERNITY MORTALITY RATE BY THREE-QUARTERS BETWEEN 1990 AND 2015

GOAL 5: IMPROVE MATERNAL HEALTH

Objective 6- To reduce maternity mortality rate by three-quarters between 1990 and 2015

Maternal health is the issue of the fifth MDG and for Angola target 6, as measured by the mortality rate of women between 12 and 49 years of age. The planned target for Angola is to reduce the 2000 indicator by three quarters in 2015.

The maternal mortality rate requires the improvement of multiple factors, including advances in prenatal care, skilled assistance at delivery, family planning and prevention of diseases prevalent in the women of the country.

A) DIAGNOSIS AND TRENDS

The Ministry of Health recorded 362 cases of women mortality in 2009, and the three most important causes were malaria (29%), pre-eclampsia (19%) and puerperal infection (10%). Of the three, puerperal infection was the only one that has increased since 2007.

According to this data, 29% of causes of death in women are linked to maternity. These cases, along with deaths from malaria, accounted for over half of deaths among women in the country in 2009 (58%).

The high maternal mortality rates were also confirmed by the indicator of 1400 women per 100,000 live births in 2006, one of the highest rates worldwide.

Given this backdrop, Angola has drawn up a National Strategic Plan to Reduce Maternal and Child Mortality, to reduce these occurrences as quickly as possible, based on the increase of primary health care.

This effort aims to lower the rate of the levels foreseen by international health organizations and meet the target set for 2015 (350 women per 100,000 live births).

For this reduction to be possible, significant progress is needed on access to primary health care, in skilled attendance during pregnancy and family planning and prevention of communicable diseases that allow the detection of maternal diseases.

The use of family planning and contraception can ensure the control of disease transmission and the number of deliveries at the right time. This way, the mother can recover so her following pregnancy and childbirth occur when she is stronger and there are appropriate nutritional conditions for the survival of the unborn child.

Preventing teenage pregnancy is also important, since young women's bodies are not properly formed due to lack of maturity. This preventive measure contributes to reducing the risk of women contracting diseases and dying during birth or early in a child's life.

Despite the importance of these measures, IBEP data (2008-2009) reveals difficulties in assisting women in these fields, although progress has been made in recent years.

According to the IBEP data (2008-2009), only 18.4% of women aged 12 to 49 years had unplanned children. Contrary to what one would expect, however, this percentage was higher in urban areas (22.0%) than in rural (13.8%). Unplanned pregnancy is inversely proportional to the age of the mother, and the fact that the proportion of younger mothers (12-14 years) was higher (46.5%) reveals the tragedy of unwanted teenage pregnancy.

Also contrary to what one would expect, is the relationship between the percentage of women who had unplanned children and their education. Women with primary and secondary level education showed similar percentages - 20.5% and 20.8%, respectively - while women with no education represented only 12.5% of mothers who had unplanned children.

One piece of information that deserves further consideration is the fact that women, who had more recent deliveries, less than a year ago, represented an increasing proportion of unplanned children. Women who gave birth one and four years ago, and five or more years ago represented 19.5% and 12.9% respectively.

Since in recent years the government has intensified maternal health care and invested in clarifying and educating women, one would expect that women with a higher level of education, whose delivery occurred more recently would have fewer unplanned children. However, IBEP statistics show a different reality, indicating the need to reassess the data and review of public policies on the subject.

Other facts shown by the information in Table 20, regarding women between 12 and 49 years of age who had children, are as follows:

- The proportion of women in the urban areas (53.9%) was higher than that in rural zones (46.1%);
- The age range that covers teenage pregnancy showed 9.5% of women had children;
- The age group where most women have had children was between 20 and 34 years, some 56.1% of the total;
- The proportion of women who had children and who have secondary level schooling (17.3%) was significantly lower than those with no schooling (31.9%) or who have primary education (49.2%).

Statistics on spacing (women who wanted to have children later) and limitation (women who did not want to have children or have any more children) are presented in Table 20.

Table 20 - The percentage of unmet family planning demands for women between 12 and 49 years who gave birth in the last 12 months (total for spacing and limiting), according to women's characteristics (2008-2009)

Categories	Women that have children	Women that had unplanned children	Unmet family planning demand by kind or need for women between 12-49 that had unplanned children	
			Spacing (1)	Limitation (2)
Angola	100.0	18.4	82.4	17.6

Place of residence				
- Urban	53.9	22.0	82.7	17.3
- Rural	46.1	13.8	81.9	18.1
Age group				
12 -14 years old	0.3	46.5	100.0	0.0
15 -19 years old	9.2	39.7	93.3	6.7
20 -24 years old	19.8	23.2	89.4	10.6
25 -29 years old	18.9	19.8	84.4	15.6
30 -34 years old	17.4	15.3	81.2	18.8
35 -39 years old	13.5	12.6	68.8	31.2
40 -44 years old	11.8	12.7	62.0	38.0
45 -49 years old	9.2	9.4	64.7	35.3
Schooling				
- None	31.9	12.5	79.5	20.5
- Primary education	49.2	20.8	81.7	18.3
- Secondary education or more	17.3	20.5	86.0	14.0
- Other or not declared	1.6	24.5	91.5	8.5

Source: IBEP (2008-2009)
(1) Spacing: Women that want to have children later
(2) Limitation Women that do not want children or do not want more children

Some points in this table deserve to be highlighted:

- 82.4% of women who had unplanned children and would have liked to have had them later with no major differences between women in urban and rural areas;
- This ratio decreases as women get older and increases with the level of education - older women were less dissatisfied with unplanned children and women in higher education said they were more dissatisfied;
- 17.6% of women do not want to have children or do not want more children and there were no major differences in relation to the area of residence;
- This proportion increases with age and decreases with education.

It is also important to note that, among women of reproductive age that are married or in a stable relationship, 17.7% used contraception, a figure that rose to nearly 27% in the cities and dropped to only 6.6% in rural areas. Male condoms were virtually unused by these women, with a national share of only 4.5%, 7% in the cities and 1.4% in rural areas.

On the other hand, when pregnancy occurs, prenatal health care allows various health complications to be controlled and these problems can be prevented or treated. Among other benefits, health care can avert children having to be born by emergency caesarean section and the birth of premature infants, which is very common in chronic hypertensive mothers with respiratory asphyxia or bleeding, and all these situations can increase the risk of maternal mortality.

Access to health care and qualified personnel are key factors for preventing and controlling risk in these cases. In this regard, and according to the IBEP database, 57, 4% of women with live births in the last 12 months, gave birth at home, compared with 42.3% in health facilities (Table 21).

Table 21 - Place of care provided to women with live births in Angola (2008-2009)

Categories	Home (%)	Health units (%)
Angola	**57.4**	**42.3**
- Urban	32.2	67.6
- Rural	84.9	14.5

Source: IBEP (2008-2009)

Most rural women were cared for at home (almost 85%), with less possibility of having qualified staff, while most of the urban mothers were cared for at health units (67.6%), with greater possibilities of having qualified personnel. In fact, 49.4% of pregnant women in the country were cared for by skilled personnel in 2008-2009; this percentage was 73.1% in urban areas, where women are attended by skilled health personnel, while in rural areas this proportion is only 23.5%.

Table 22 - Percentage of women 12-49 years of age with live births in Angola, in the last 12 months, who were cared for during childbirth by skilled health personnel, according to women's characteristics (2008-2009)

Categories	Percentage of women
Angola	49.4
Place of residence	
- Urban	73.1
- Rural	23.5

Source: IBEP (2008-2009)

As for prenatal care of women from 12 to 49 years who gave birth in the last 12 months, IBEP data revealed that 31% had no consultation in 2008-2009. This rate is almost three times higher in rural areas (47.3%) than in cities (16.5%).

Maternal care decreases as women grow older and their education level is lower, with greater prevalence in young women with higher education, though the system does not discriminate against any category of woman.

The importance of care during pregnancy and childbirth is essential because it reduces deaths caused by obstetric problems. But it is still far from ideal, because only about half the population of childbearing age throughout the country, had assistance from qualified health professionals.

Rural women, or those that are older and less educated, with access to less information and faced with the harshest conditions, can count on less prenatal care and are more likely to have births with less qualified staff.

Table 23 - Percentage of women 12-49 years old with children in Angola in the last 12 months, by number of prenatal visits made during the last pregnancy, according to area of residence, age and educational level (2008-2009)

Categories	Number of appointments				
	0	1	2	3	4 or +
Angola	31.0	3.2	5.8	12.8	47.1
Place of residence					
- Urban	16.5	2.5	6.0	14.1	60.9
- Rural	47.3	4.1	5.6	11.3	31.7
Age group					
12 -14 years old	37.0	10.7	0.0	4.9	47.3
15 -19 years old	26.6	5.3	6.7	19.0	42.4
20 -24 years old	28.0	3.6	6.5	12.7	49.0
25 -29 years old	26.9	2.7	3.8	12.3	54.2
30 -34 years old	34.7	2.9	6.4	10.5	45.3
35-39 years old	38.4	1.4	7.4	7.5	45.2
40-44 years old	42.7	1.3	4.6	17.3	34.1
45-49 years old	58.5	3.8	3.8	4.7	29.2
Schooling					
- None	48.4	4.9	5.7	11.8	29.3
- Primary education	27.7	3.1	6.8	13.7	48.6
- Secondary education or more	11.5	0.8	3.6	11.8	72.3
- Other or not declared	12.2	0.3	0.2	12.7	74.1

Source: IBEP (2008-2009)

B) CHALLENGES

The overall health of women, particularly pregnant women, represented a major challenge for the country, not to mention the impact it has on families and children.

In this context, poor rural women, who are older and poorly educated were the most vulnerable part of a picture of poor health, because the health care they received, apart from the inherent shortcomings in the services and the difficulties in reconstructing the country, is hampered by their lack of leadership and their acceptance of precarious living situations.

Given this framework, the maternal health care policy, by its extension and the seriousness of the problem, must be highly efficient in the coordination between actions and instruments, not only within the Ministry of Health, but also the Ministry of Education, the Ministry of Family and Women's Promotion, the Ministry of Social Welfare, Provincial Governments and civil society organizations, all acting in coordination.

The use of the media also has to be intensified as well as the use of workplaces and schools to educate and inform people about diseases and the steps to be taken to promote health, pregnancy planning, contraceptive methods, and to avoid maternal health care with traditional methods and the unsafe use of unqualified midwives.

Greater diagnosis must be made into the causes of maternal deaths and diseases such as colon and breast cancer and to mobilize popular forces and local leaders for community work in the prevention of maternal and perinatal deaths.

Many of these challenges show the need for designing a women's health care strategy to ensure overall care, by building collective help networks that include all stages of the cycle, from caring attention, pre-conception, conception, delivery and caring, postnatal care and attention to child development up to the age of five.

C) POLICIES AND PROGRAMMES

The government's actions in this field are embodied in the National Strategic Plan for Reproductive Health, especially the following initiatives:

a) Municipal health care system for women - An initiative which includes bolstering local health systems, supplying an essential care package, improving access and quality of child care and the quality of reproductive health, mobilizing society to promote maternal and child health and monitoring and assessing the schemes;

b) Maternal health care in Damba Municipal Hospital of - Promoting lifelong learning to centre technicians, health posts, and a complete package to prevent and treat people's most common diseases, in the units area of intervention, using mobile and advanced. This work is a national benchmark.

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

OBJECTIVE 7- TO STOP AND BEGIN REDUCING HIV/AIDS PROPAGATION

OBJECTIVE 8- TO STOP AND BEGIN REDUCING INCIDENCE OF MALARIA AND OTHER SERIOUS DISEASES BY 2015

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

The epidemiological profile of the Angolan population includes endemic and infectious diseases with a high impact on health, working capacity and quality of life.

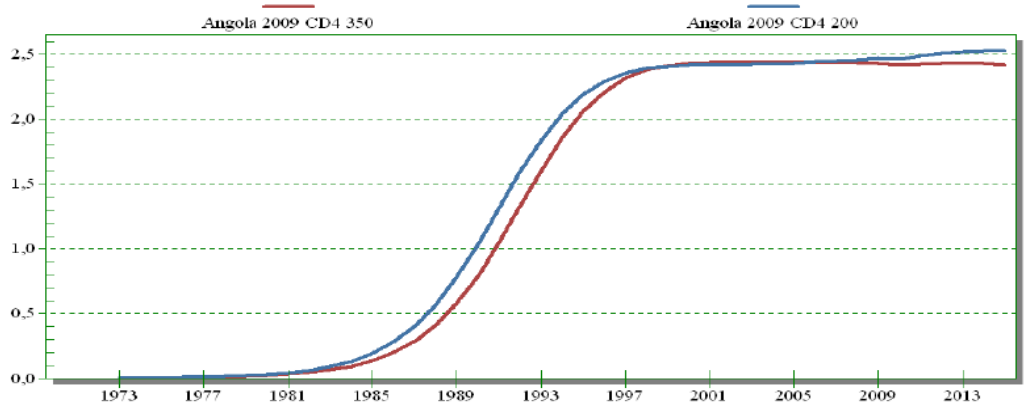
The control and treatment of these diseases are covered by MDG 6, including two objectives, reducing the spread of HIV/AIDS and reducing the incidence of malaria and other serious illnesses. Seven indicators are involved in the measurements, three associated with controlling HIV/AIDS, two for malaria and two for tuberculosis.

Objective 7- To stop and begin reducing HIV/AIDS propagation

Objective 8- To stop and begin reducing incidence of malaria and other serious diseases by 2015

A) DIAGNOSIS AND TRENDS

Angola has the lowest HIV sero-prevalence compared with other southern African countries. There were 14,893 registered cases of HIV/AIDS in 2009, which corresponds to 2.4% of the population between 15 and 49 years of age. This number was slightly higher than seen in 2007. The progress of HIV since the 70s is shown in Figure 9.



Source: EPP estimates/Spectrum 2010

Figure 9 - HIV among adults 15-49 years with CD4 <200 and CD4 <350

According to Figure 9, HIV in Angola has changed over three periods of time. From 1973 to 1985, prevalence rose gently, remaining under 0.5% throughout the period. From 1985 until 1997, the trend changed and the rate began to grow rapidly, rising to about 2.4%.

From then until 2009 the rate stabilized at levels close to 2.4%.

The main HIV / AIDS indicators and statistics for Angola in 2009 are shown in Table 24.

Table 24 - Estimates of HIV/AIDS in Angola (2009)

Indicators	Values
Prevalence in adults (%age)	2.4%
No. of people who live with HIV	210,775
No. of children 0-14 with HIV	28,367
No. of women who live with HIV	127,617
No of adult deaths between 15 and 49 years old	3,929
No of children's deaths between 0 and 14 years old	3,531
No of AIDS orphans between 0 and 17 years old	12,597

Source: Forecasts based on the Spectrum Programme:

According to these estimates, 210,775 people lived with HIV in Angola in 2009, more than half of whom were women. There were 28,367 infected children, 12,597 of whom were AIDS orphans. 6460 adults and children died of the disease in 2009.

Risk behaviour and disease prevention using condoms help to better understand the way the disease spreads. Table 25 shows that only 39.3% of people of 12 or older who had sex with more than one partner in the last 12 months use condoms. The differences in the value of this indicator, in terms of people's areas of residence are quite significant - 52.1% for people from urban areas and only 18.8% for rural people.

The behaviour of people who use condoms, according to age, reproduces a curve, lower in the first age group (12-14 years - 23.9%), then increasing to reach a maximum in those aged 20-24 years (54.9%) and starting to fall again for the older age groups, bottoming out at 2.6% for the 60 to 64-year-olds.

The level of education has a positive effect on the proportion of people who used condoms, increasing with education (Table 25).

Table 25 - Proportion of people with 12 or more in Angola who had sex with more than one partner in the last 12 months using a condom (2008-2009)

Categories	Percentage
Angola	39.3
Place of residence	
- Urban	52.1
- Rural	18.8
Gender	
- Male	38.8
- Female	43.0
Schooling	
- None	9.6
- Primary education	26.2

- Secondary education or more	54.5
- Other or not declared	61.3

Age group			
Age	Percentage	Age	Percentage
12 -14 years old	23.9	40 -44 years old	26.8
15 -19 years old	47.2	45 -49 years old	19.0
20 -24 years old	54.9	50 -54 years old	11.8
25 -29 years old	48.5	55 -59 years old	6.1
30 -34 years old	36.4	60 -64 years old	2.6
35 -39 years old	33.0	65 or over	7.3

Source: IBEP (2008-2009)

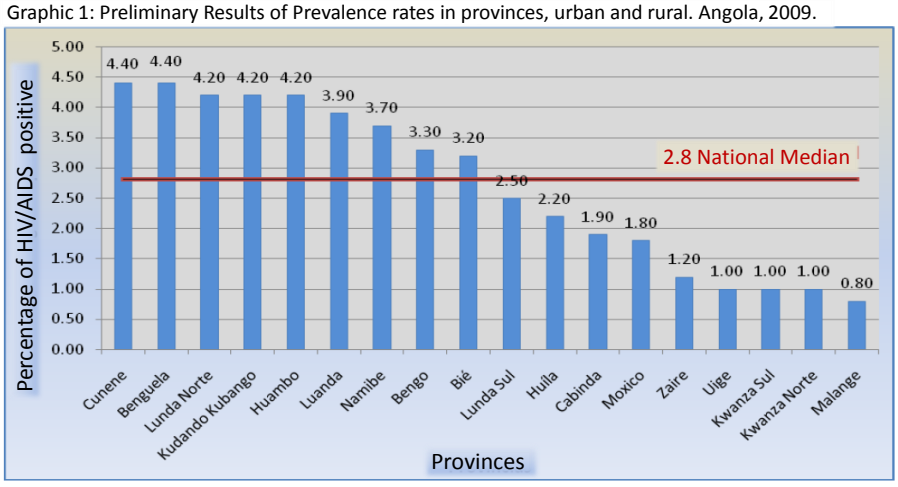
The sero-prevalence study (2009), held in 36 locations (urban and rural), shows significant differences among the 18 provinces, as can be seen in Figure 10.

According to this survey, the average prevalence rate was 2.8%. Of the nine provinces that had a prevalence above average, five have values higher than 4.2% (Cunene, Benguela, Lunda Norte, Huambo and Kuando). Of the nine provinces with prevalence below the average, five had values close to 1% (0.8 to 1.2%) - Zaire, Uige, Kwanza Sul, Kwanza Norte and Malange.

It should be noted that the border provinces in the north of the country (Cabinda and Zaire) had lower prevalence rates compared to the provinces bordering the South (Cunene and Kuando) and east (Lunda Norte and Lunda Sul).

The border province with the lowest prevalence rate was Moxico, with 1.8%.

Graphic 1: Preliminary Results of Prevalence rates in provinces, urban and rural. Angola, 2009.



Fonte: Estudo de Seroprevalência em grávidas, 2009

Source: Seroprevalence study (2009)

Figure 10 – HIV/AIDS seroprevalence study in Angola by province in2009

The highest prevalence of HIV/AIDS in pregnant women between 15 and 49 years old in 2009 was 2.8%. In the 2004, 2005 and 2007 reports, the highest prevalence occurred among women between 25 and 29, with 3.2% (2004), between 30-34, with 3.5%

(2005), and between 25-29, with 4% (2007). It is not yet possible to say that this data shows a trend, but at least in relation to the series analysed, we can see that the highest prevalence decreased and shifted to younger women.

The national average prevalence of HIV was higher among women with higher levels of schooling. Prevalence in 2007 was 3.6% among women with the third level of basic schooling or more, compared to 2.4% among illiterate women.

This finding seems to contradict the logic that more knowledge would be directly correlated with the best chance of controlling the disease. However, these statistics may be reflecting the fact that the more educated women are those that seek out and have access to prenatal medical appointments and therefore the highest number of tests. The lack of health care by women with less schooling contributes to underestimating the prevalence of HIV/AIDS among them.

The national prevalence of unmarried women was four times higher than that of married women. Furthermore, in the 2004 and 2007 studies, women with more children had higher prevalence rates than women who were pregnant for the first time.

In regard to knowledge and information on HIV/AIDS, Table 26 shows that 47.5% of people between 15 and 49 knew two forms of prevention, 32.5% had three misconceptions, and 23.6% had misconceptions about transmission and about HIV/AIDS conceptions in 2009.

Differences based on where those infected live are significant. Just considering the indicator on the knowledge of "two ways of preventing sexual transmission," the proportion in urban areas was nearly 62%, while in rural areas this figure was only 27%.

Even with respect to this indicator, knowledge increases with education level and shows no pattern of differences according to age.

Table 26 - Percentage of people aged 15 to 49 in Angola with correct knowledge of HIV / AIDS, according to aspects of knowledge and population characteristics

Categories	Learn		
	Two ways to oid sexual transmission	Three wrong ideas	Wrong ways and ideas
Angola	47.5	32.5	23.6
Place of residence			
- Urban	61.6	46.6	34.3
- Rural	26.9	12.0	7.9
Age group			
15 -19 years old	48.3	32.4	24.2
20 -24 years old	53.9	37.2	27.2
25 -29 years old	49.9	36.8	26.6
30 -34 years old	48.0	32.4	23.3
35 -39 years old	44.8	29.1	19.4

40 -44 years old	41.1	27.5	21.0
45 -49 years old	33.7	22.9	15.3
Schooling			
- None	21.5	8.6	5.9
- Primary education	46.7	26.2	18.1
-Secondary education or more	72.3	64.8	49.0
- Other or not declared	66.6	54.3	39.7

Source: IBEP (2008-2009)

This disease affects the entire family economically and financially, given the debilitated nature of an infected person who is not treated and who can often lose their job and thus reduce the family income. Furthermore, orphaned children, apart from losing their parents, have difficulty finding family or other support to continue their life with access to proper nutrition and education. Most children had both parents alive and live with at least one of them (73.1%). School attendance of these children was greater than that of children orphaned by their father and mother. Differences between rural and urban residents were small and there are virtually no gender differences (Table 27).

There were, however, differences between attendance between orphans with one surviving parent and orphans of both parents, particularly in school attendance of the urban residents (78%) and girls (75.6%), but the proportion of two-parent orphans was very low (1.4%), so these differences may have not been very relevant.

Table 27 - Ratio of school attendance by orphans compared with non-orphaned children between the ages of 10-14 in Angola, according to area of residence (2008-2009)

Categories	Lost both biological parents		Both parents are alive and they live with at least one of them		Time between attending
	Percentage	School attendance rate	Percentage	School attendance rate	
Angola	1.4	73.9	73.1	86.7	85.2
Place of residence					
- Urban	1.4	71.8	69.2	92.0	78.0
- Rural	1.4	76.5	77.9	81.0	94.4
Gender					
- Boys	1.4	84.9	74.5	88.9	95.5
- Girls	1.4	64.0	71.8	84.6	75.6

Source: IBEP (2008-2009)

The Voluntary Testing and Counselling services (VCT) have been extended beyond the provincial capitals from 154 in 2007 to 233 in 2009, with the aid of fixed and mobile units. The integration of the ATV program in the state health centre network and the

inclusion of HIV testing in clinics with antenatal services allowed the expansion of VCT activities (Table 28):

- The number of units providing VCT services increased from 57 in 2007 to 174 in 2009;
- The number of pregnant women tested in 2009, has increased by 51.6% compared to 2007.

All these services are now available in all 18 provinces.

Table 28 - Number of people served by VCT services in Angola (2007-2009)

Year of Implementation	Number of VCT Services	Number of people served
2007	98	161,349
2008	86	277,377
2009	246	288,290
Total	508	727,016

Source: INLS

It can be argued that the number of people living with HIV that are being monitored has increased in proportion to the expansion of health facilities that offer these services:

- The number of adults and children with advanced HIV infection receiving antiretroviral therapy free of charge rose from 7,884 in 2007 to 20,640 in 2009;
- Antiretroviral therapy in pregnant women doubled from 6% in 2007 to 12% in 2009 and is successful in preventing vertical transmission of HIV.

The prevention strategy of vertical HIV transmission has reduced the transmission of infection in exposed children. There was a reduction in the percentage of infected infants born to infected mothers (2.7%) in 2009, compared with 2004 (3.3%) and 2007 (3.3%).

Services providing antiretroviral treatment increased from nine in 2004 to 494 in 2009, in 251 fixed health units (the National Health System) and 77 mobile units in 111 of the 164 municipalities (67.7%) in the country, with an estimated population coverage of approximately 80%.

Combating malaria and other diseases

Regarding malaria and other infectious diseases, we have seen a reduction in the number of infected people, although the national pathological situation is still dominated by communicable diseases.

Malaria is endemic throughout the country and is the leading cause of death. The provinces have been divided into levels of threat according to vulnerability to communicable diseases ranging from the most serious hyper-endemic situation to moderately stable and moderately unstable, as can be seen in Table 29 (Mis2 - Malaria Indicator Survey, 2006-07).

Table 29 - Malaria in Angola, Threat of malaria (epidemiological regions), provinces affected, vectors, parasites, percentage of population affected and the transmission period

Threat Level	Provinces	Vectors	Parasites	Population affected	Transmission period
High Threat	Cabinda, Uíge, Kwanza Norte, Malange, Lunda Norte, Lunda Sul	*A. funestus* *A. mangmblae*	*P. falciparum (89%)* *P. vivax (7%)*	28%	Transmission all years round, highest November to January
Moderate Stable Threat	Zaire, Luanda, Bengo, Benguela, Kwanza Sul, Huambo, Bié	*A. gamblae* *A. melas* *A. arablensis*	*P. falciparum (93%)* *P.vivax (7%)*	25%	High transmission November to May Low transmission July to October
Moderate Unstable Threat	Moxico, Kuando Kubango, Cunene, Huíla, Namibe	*A. arablensis* *A. melas*	*P. falciparum (93%)* *P. vivax (7%)* *P. malarie (5%)*	17%	Low transmission May to December

Sources: MARA'ARMA, 2002; NMCP, 2005

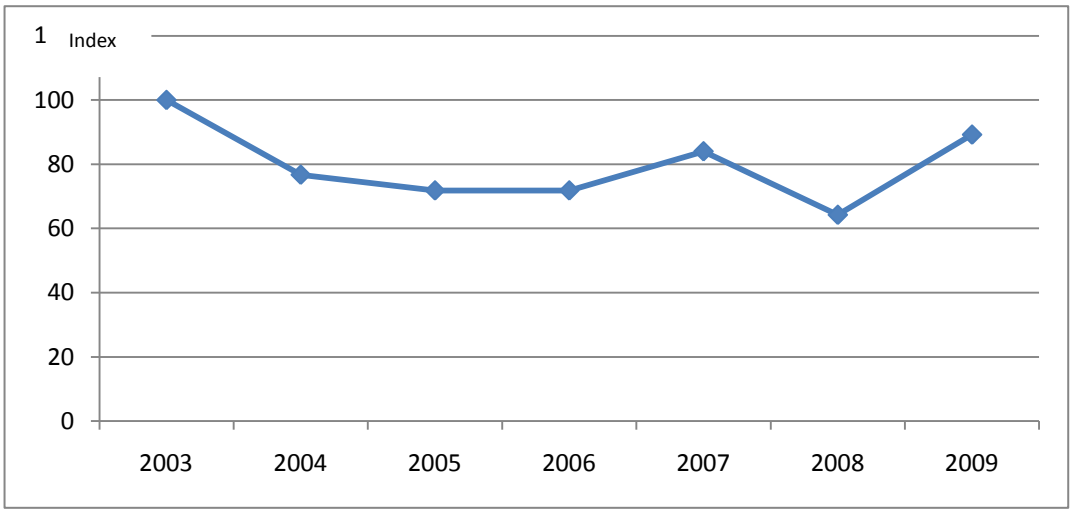
2,896,971 cases of malaria were reported in 2009, about 65% of the most common diseases, compared with 71% last year. There was an average of 2,568,828 cases a year over the past three years. The fatality rate, has, on the other hand, fallen consistently over this period, stabilizing at 0.3% per year (Table 30).

Table 30 - Number of cases of malaria notified in Angola (2003-2009)

Indicators	2003	2004	2005	2006	2007	2008	2009
Notifications	3,246,256	2,489,170	2,329,316	2,283,097	2,726,530	2,082,982	2,896,971
Fatality rate	1.2	0.5	0.6	0.4	0.3	0.3	0.3

Source: Ministry of Health

Figure 12 shows the number of malaria cases, using 2003 as base 100. After the fall of the number of cases from 2003 to 2004, the number hovers around an average of 2.58 million cases over the seven years. The hope is to reduce such occurrences, given recent government measures.



Source: Ministry of Health

Figure 12 - Change in the number of cases of malaria in Angola (2003-2009)

Children under five and pregnant women are most vulnerable to malaria. The disease incidence rate for children under-five fell from 35% in 2003 to 23% in 2010, a 12% reduction (UNICEF, 2010).

According to IBEP data for the population who had a fever or malaria within 30 days prior to the survey, the population with a higher incidence continues to be from rural areas: 16.5% in urban areas and 18.4% in rural areas.

The lowest incidences were found in Malange province and the highest is in Bie and Lunda Norte. The moderately stable endemic level is in the central, northern and western zones, i.e. where most people live, since the north borders with the Democratic Republic of Congo, a country with high prevalence of communicable diseases.

In regard to ways to combat and treat malaria, the information about the use of mosquito nets as a preventive method has been a good lead. According to IBEP (2008-2009), 17.7% of households reported owning at least one mosquito net treated with insecticide, this proportion was 20.8% in urban areas and 14.1% in rural areas. Figures for the use of mosquito nets for children and pregnant women are presented in Table 31.

Table 31 - Percentage of children and pregnant women in Angola, who slept under an insecticide treated mosquito net the night before the survey (2008-2009)

Indicator	**Percentage**		
	Total	Urban area	Rural area
Children of 0-4 years of age	16.4	19.1	13.3
Pregnant women 12-49 years old	18.4	20.2	16.2

Source: IBEP (2008-2009)

It also highlighted the greater use of mosquito nets in Cabinda province (38.9%) and less use in Bie province (2.8%), which may explain the difference, also found among children with the same age who had fever or malaria in Cabinda (9.8%), one of lowest in the country, unlike Bie (15.8%), the highest in the country.

9% of the urban population and 12.8% of the rural population had antiretroviral treatment. The highest frequency of treatment with these drugs was in Bengo province whereas Benguela had the lowest. The first was in a hyper-endemic area and the second in moderate stable endemic area.

Paracetamol and Coartem have frequently been used to treat the disease and Coartem is a latest generation antimalarial treatment.

36.5% of children 0-4 years who had a fever in the last 30 days took appropriate antimalarial drugs within 24 hours. This percentage was 39.6% in urban areas and 33.5% in rural areas

Table 32 - Percentage of children 0-4 who took antimalarial drugs within 24 hours of malaria symptoms in Angola (2008-2009).

Categories	Percentage
Angola	36.5
Place of residence	
- Urban	39.6
- Rural	33.5
Gender	
- Boys	32.3
- Girls	40.6
Age	
0-11 months	20.3
12-23 months	22.4
24-35 months	18.5
36-47 months	13.1
48-59 months	12.5

Source: IBEP (2008-2009)

Pulmonary tuberculosis, which incapacitates those affected, was also a serious problem in Angola, which should take into account the spread of this disease, often associated with HIV/AIDS. The prevalence rate was 256/100.000.

The cases of tuberculosis and typhoid are shown in Table 33.

Table 33 - Number of cases reported in Angola (2007-2009)

Diseases	Number of cases			Variation (%)	
	2007	2008	2009	2008	2009
Typhoid	49,181	101,745	135,971	107	34
Tuberculosis	5,735	34,956	42,383	510	21

Source: GEPE- MINSA

B) CHALLENGES

In addition to keeping these diseases under control and encouraging lower prevalence, health policy must protect the most vulnerable groups, children and pregnant women, and reduce disparities between the urban and rural areas and between women with higher or lower levels of education.

Prevention is, itself, better than curing a disease therefore educating the population and encouraging preventive practices that attack transmission of diseases are very effective strategies. The obstacles that arise include difficulties in communicating with the rural population and peoples' level of education.

Once contaminated, access to appropriate treatment becomes the next line of attack. Once again, pregnant women and children should be the focus of this policy, due to their vulnerable condition.

Partnerships with civil society representatives who act in the province is one way for the government to get a return on the effort and investment it has invested, through synergies and integrated organization and intervention.

Overcoming these challenges, however, requires stronger government bodies to run the actions, greater participation in the budgetary resources for current spending and investment and, in particular, strengthening and training teams.

C) POLICIES AND PROGRAMMES

The measures the government planned in order to address these challenges include:

a) Promotion of proper knowledge as to the causes that lead to HIV;

b) Mobilization of the Angolan armed forces for HIV prevention, which involves a series of measures that make the army one of the few in the world with a comprehensive prevention programme throughout the country;

c) Expansion of HIV prevention measures, as the Voluntary Testing Counselling and Program, which has reached a greater number of HIV-positive mothers, and has caused a greater impact on demand for HIV prevention;

d) Continuous and systematic maintenance and development of distributing mosquito nets;

e) Provision of miscellaneous information and materials to make people aware of malaria, tuberculosis and leprosy;

f) Campaigns spraying areas with stagnant water to reduce the spread of malaria;

g) Educational campaigns on city hygiene, especially in the poorest neighbourhoods.

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

OBJECTIVE 9- TO INTEGRATE THE PRINCIPLES OF SUSTAINABLE DEVELOPMENT INTO NATIONAL PROGRAMMES AND POLICIES TO TURN AROUND THE CURRENT TREND OF LOSING ENVIRONMENTAL RESOURCES

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

Objective 9- To integrate the principles of sustainable development into national programmes and policies to turn around the current trend of losing environmental resources

The goal of ensuring environmental sustainability is part of the MDGs for sustainable development, in terms of promoting progress without depleting natural resources or jeopardizing the quality of life of future generations.

The goal of this objective is associated with the protection of forest areas, biodiversity, the efficient use of energy and controlling the emission of carbon dioxide in the atmosphere.

A) DIAGNOSIS AND TRENDS

Angola is rich in natural resources. The country's geographical location and size means it has a very significant diversity in natural resources, such as a vast river system, a superabundant native forest, a wide variety of wildlife resources, vast areas of arable land, valuable mineral resources and a coastline with great economic and environmental potential.

Out of the 53 million hectares considered as forests (43.3% of the country's surface), only 2% were high productivity dense rain forests with rich biodiversity. Of these, 65.2% were made up of a mosaic of forests, savannah, and open woodlands with some logging, that were socially and economically important for the production of wood fuel, construction materials, medicinal plants, and non-timber products for food.

Only 24.000km^2 of the total area was classified as high biological diversity forests with greater capacity for carbon sequestration, mainly in the provinces of Cabinda, Zaire, Bengo, Kwanza Norte and Uige.

Legal logging was estimated at about 326.000m^3/year. The deforestation rate was 0.4%/ year, or some 2.120km^2 a year.

Deforestation contributes to a loss of biological diversity and reduced ability to sequester carbon. Other factors affecting the forests are farming practices, forest fires and the demand for firewood and charcoal production.

The destruction of roads, however, limited the supply of farm supplies that could improve the use of arable land and thus avoid the deterioration of natural resources with damaging effects on the environment.

Moreover, most of the population in rural and suburban areas continues to use biomass as their sole source of energy, due to the scarcity and cost of fuel, which also contributes to deforestation.

There has, however, been rise in civil organizations that struggle for national environmental protection and public awareness of environmental issues. The results

are not yet satisfactory though, due to lack of regular inspection to enforce environmental legislation.

Another factor associated with ensuring environmental sustainability in Angola is the flaring of gas associated with oil production, which is a waste of natural resources and an environmental problem.

Depending on the composition of the hydrocarbons that are produced, the main compounds that may exist in gas flare emissions are nitrogen and sulphur oxides (SOx and NOx), carbon monoxide and carbon dioxide (CO and CO2), water vapour and un-burnt hydrocarbons.

Estimates indicate that Angola produced 30% of the gas flared in Africa and about 3% of the global total in 2000. Studies conducted by the Ministry of Petroleum in 2007 showed that about 22% of the gas was used, 55% was stored for future use and 21.45% was burnt (Table 34).

Table 34 - Total gas production for 2006 (in million m^3)

Production	Quantity	Percentage
Gas produced	26,333.34	100.0
Gas consumed as fuel	2,953.40	11.22
Gas burnt	5,647.70	21.45
Gas injected into wells to maintain flow	2,820.00	11.00
Gas stored for future use	14,380.40	55.00

Source: National Oil Department/ Oil Ministry (2007)

There are several other sources of greenhouse gases in Angola, many of which lie at the basis of the energy needs of the population. These basic needs are mainly related to the production of fossil fuels and biomass. First of all, it is highly unsustainable and emits atmospheric greenhouse gases. Secondly, despite being renewable, it contributes to a loss of biological diversity and introduces greenhouse gases in the atmosphere, especially carbon dioxide (CO2).

WB MDG Indicators show the growth rate of CO2 emissions in Angola was approximately 0.1 metric tons per capita per year between 2000 and 2007.

Thus, the activities in Angola that can affect the main atmosphere parameters and contribute to global warming include: deforestation, the burning of gas associated with oil production, transport systems that favour individual rather than collective transport; energy production from fossil fuels, some agricultural practices and uncontrolled forest fires.

It was not, however, possible to measure this impact, but this initiative is already included in the actions of the Angolan government, along with creating a national inventory of emissions and a national climate change program.
In addition, measures are under way to promote the systematic eradication of gas flaring in the country's oil industry.

It is important to mention that about 6.6% of the country is intended for conservation (parks, reserves and game reserves) and this incorporates a variety of ecological zones, notwithstanding rainforests.

Table 35 - Environmental protection areas in Angola in 2010

Name	Province	Area (in km^2)
National parks		
Bikuar national park	Huíla	**7.900**
Cameia national park	Moxico	**14.450**
Cangandala national park	Malanje	**630**
Iona national park	Namibe	**15.150**
Kissama national park	Bengo	**9.960**
Mupa national park	Cunene	**6.600**
Regional parks		
Chimalavera regional national park	Benguela	**150**
Reserves		
Namibe partial reserve	Namibe	**4.450**
Búfalo partial reserve	Benguela	**400**
Mavinga partial reserve	Kuando Kubango	**5.950**
Luiana partial reserve	Kuando Kubango	**8.400**
Ilhéu dos Pássaros full nature reserve	Luanda	**2**
Luando full nature reserve	Malanje/Bié	**8.280**
Game parks		
Ambriz game park	Bengo	**1.125**
Longa-Mavinga game park	Kuando Kubango	**26.200**
Luengué game park	Kuando Kubango	**13.800**
Luiana game park	Kuando Kubango	**11.400**
Milando game park	Malanje	**6.150**
Mucusso game park	Kuando Kubango	**21.250**

Source: Ministry of Environment (2010)

The situation of these areas and parks, including those created in colonial times, still requires government measures to improve the administration, supervision and degraded infrastructures and to protect the biodiversity of these areas, against squatters, hunting and fires.

In addition to the aforementioned terrestrial ecosystems, Angola also has enormous biodiversity in the aquatic ecosystem (freshwater, marine and coastal), a leading marine biodiversity centre and one of the most productive fishing areas in the world.

The 1,650 kilometre long Angolan coastline, is of great importance for ecological processes and local plants and animals. At least 26 perennial rivers flow into the Angolan coast, while many others additionally flow north, east and south-east. Some of these rivers spread out over vast river basins, creating huge riparian forests and associated wetlands. According to WB indicators, however, only 4% of the total surface area of these waters is protected.

Large estuaries, rivers like the Congo, Dande, Kwanza and Cunene rivers are the basis for an intricate network of species and provide support to major food chains that are essential for the survival of the population, including those from the neighbouring countries.

In fishing terms, appropriate legislation was developed, based on fisheries management and planning, pursuant to the FAO Code of Conduct for responsible fishing and sustainable resources.

Generally, the biomass situation has not significantly changed, so there is a need to strengthen the management measures for species with a high commercial value, as well as those used most by the local population. Traditional fishing is still worthy of attention as it reduces poverty, hunger and unemployment.

Fishing activity in Angola in 2006 to 2008 is shown in Table 36. Note the performance of the industrial sector and frozen fish in particular.

Table 36 – National maritime fish catches (2006-2008)

Segments	Capture in tons			Variation (%age)		
	2006	2007	2008	2006	2007	2008
Industrial	83,265	18,815	102,460	30.22	-77.40	444.55
Semi-Industrial	43,950	127,983	93,061	-15.66	191.20	-27.29
Traditional	87,734	118,403	63,231	14.59	34.96	-46.60
Total	**214,949**	**265,201**	**258,751**	**11.59**	**23.38**	**-2.43**
Source: Ministry of fisheries (2008)						

There are also mangrove forests along the Angolan coast with ecosystems of enormous biological and ecological importance, providing shelter and nurseries for fish and shellfish of economic importance and tourism to the country.

On the other hand, water management has been geared towards improving production, processing and distribution, to ensure more regular provision of services to meet growing consumption and the improvement of infrastructure conditions, to support domestic production.

The public water supply system is running the Water for All Programme, which hopes to increase the supply of treated water to municipalities, communes and rural areas, one of the government's major concerns, to 113,130 m^3 per day.

According to preliminary IBEP data (2008-2009), 42% of the population had access to drinking water, in urban areas this percentage increased to 57.9% and in rural areas it

was 22 8%. The number of households described as occupied or self-built, that have access to proper drinking water were lower than those of other categories, at 36.1% and 32.8%, respectively. Households occupied by people with higher levels of education have greater proportion of drinking water than others (Table 37).

Table 37 - Percentage of the population using improved sources of drinking water in Angola, by population and housing characteristics (2008-2009)

Categories	Percentage
Angola	42.0
Place of residence	
- Urban	57.9
- Rural	22.8
Schooling of head of household	
- None	25.6
- Primary education	37.2
- Secondary education or more	55.5
- Other or not declared	53.6
Accommodation	
- Rented	63.2
- Owned	55.9
- Offered for use	58.0
- Occupied	36.1
-Self-built	32.8

Source: IBEP (2008-2009)

As for sanitation, IBEP (2008-2009) data shows that 59.6% of the country's households had access to proper sanitation, which means that they used drainage systems, traditional or improved latrines and public latrines. In urban areas, this percentage was 82.5%, while it was only 31.9% in rural areas (Table 38).

Table 38 - Proportion (total and by area of residence) of population using improved sanitation facilities

Categories	Percentage
Angola	59.6
Place of residence	
- Urban	82.5
- Rural	31.9

Source: IBEP (2008-2009)

When one analyses simultaneous access to water and sanitation, the proportion of households using improved water source and adequate sanitation was 31.7% nationally (42% with access to water and 59.6% with access to sanitation). The ratio

between rural and urban households was nearly a fifth, i.e., almost 11 in 100 rural households had access to these two services while in urban areas the figure was nearly 50%. Furthermore, access to these benefits increased dramatically as education of the household occupants increased (Table 39).

Table 39 - Proportion of population using an improved source of drinking water and improved sanitation facilities, by population and housing characteristics

Categories	Percentage
Angola	**31.7**
Place of residence	
- Urban	49.3
- Rural	10.5
Schooling of head of household	
- None	12.8
Primary education	24.6
- Secondary education or more	49.5
- Other or not declared	44.6

Source: IBEP (2008-2009)

Many urban dwellers also lived in slums with very poor conditions that had an extremely negative impact on the environment and were subject to high transportation costs. According to the 2010 UNICEF report, 87% of urban dwellers lived in a satellite town.

Taking into account these conditions, the government drew up a programme to build one million houses by 2012, which is currently under way and that will change the country's housing situation.

Table 40 - Percentage of urban dwellers and households in Angola, who live in slums

Categories	Households	Population
Angola	90.0	90.9
Schooling of head of household		
- None	97.6	97.3
- Primary education	93.6	93.9
- Secondary education or more	85.8	87.5
- Other or not declared	92.4	94.4

Source: IBEP (2008-2009)

B) CHALLENGES

Among the inherent challenges in this area, is the need to promote sustainable use of forests and improved management and conservation of parks and forest reserves and their biodiversity, apart from controlling factors that may harm the environment.

There is also the challenge of providing infrastructures to supply drinking water to the population and proper sanitation, due to its importance in terms of public health and reducing mortality. In the case of sanitation, there is the negative impact caused by a lack of health infrastructures.

These challenges are even greater in the actions aimed at rural populations and people with lower levels of education, who have the lowest indicators of access to these public services.

Another challenge is the urbanization of slums and the provision of housing to meet current demands across the country.

Finally, it should be noted that the government and institutions have also tried to address these difficulties and increase the capacity to enforce environmental laws.

C) POLICIES AND PROGRAMMES

The Angolan government has defined a framework of policies, instruments and governmental agencies to solve the country's environmental problems, such as:

- Environmental base law (5/98);
- Environmental defence association law;
- Land law;
- Town planning and territorial ordinance law;
- Decree on environmental impact assessment.

They have also set up government schemes to oversee the following programmes:

- Combating erosion;
- Environmental management;
- Replanting forests;
- Combating desertification;
- Education and awareness;
- Creation of environmental awareness units within the Agricultural development Stations (EDAs);
- Improving traditional agriculture techniques;
- Construction of 1 million homes by 2012;
- Water for All programme;
- Integrated coastline management;
- Prohibition of mackerel fishing;
- Systematic eradication of gas flaring in the oil industry.

On the other hand, the adoption of important policy documents, such as the Environmental Management Program, the National Strategy on Biodiversity and

regulations of the law on environment remain at the top of the list for overcoming the environmental sustainability challenges.

GOAL 8: BUILD GLOBAL DEVELOPMENT PARTNERSHIPS

OBJECTIVE 12- TO CONTINUE DEVELOPING AN OPEN, MULTILATERAL FINANCIAL AND COMMERCIAL SYSTEM THAT IS REGULATED, FORESEEABLE AND NON-DISCRIMINATORY (INCLUDING THE COMMITMENT TO GOOD GOVERNANCE, DEVELOPMENT AND REDUCTION OF POVERTY – BOTH DOMESTIC AND INTERNATIONAL)

OBJECTIVE 17- TO PROVIDE ACCESS TO ESSENTIAL MEDICINES AT AFFORDABLE PRICES IN COOPERATION WITH DRUG COMPANIES

OBJECTIVE 18- TO MAKE ACCESS TO THE BENEFITS OF NEW TECHNOLOGIES, PARTICULARLY ICT, ACCESSIBLE IN COOPERATION WITH THE PRIVATE SECTOR

GOAL 8: BUILD GLOBAL DEVELOPMENT PARTNERSHIPS

Objective 12- To continue developing an open, multilateral financial and commercial system that is regulated, foreseeable and non-discriminatory (including the commitment to good governance, development and reduction of poverty – both domestic and international)

Objective 17- To provide access to essential medicines at affordable prices in cooperation with drug companies

Objective 18- To make access to the benefits of new technologies, particularly ICT, accessible in cooperation with the private sector

This objective includes a wide variety of topics that constitute a development agenda that is embodied in a set of seven targets (MDG 12-18), which apply to developing and developed poor countries plus landlocked countries or small island countries or cities.

Targets 12, 17 and 18 are analysed in this report as they are either more relevant to Angola, or because they have not yet been dealt with directly through the other MDG objectives.

A) DIAGNOSIS AND TRENDS

Since conflict ended in 2002, the Government has been dedicated to rebuilding the country, in many several ways, namely:

a) Physically, through the reconstruction of basic and socio-economic infrastructures;

b) Institutionally, by creating a legal and institutional framework for managing the development, financing and development of business and community initiatives;

c) Macro-economically, through the design and practice of sound, rational macroeconomic policies as a basis for long-term progress and the progressive integration of Angola in the global world, and also by promoting the country's international competitiveness;

d) Politically, through major advances in the democratic process and the guarantee of universal individual rights;

e) Socially, through the design and implementation of public policies that promote equal opportunities, regardless of creed or gender, with progress in improving the quality of life.

Governance and macroeconomic stability are two fundamental pillars to ensure the changes that have taken place in Angola since the beginning of this century.

Since 2002 the country has progressed in its ability to design, implement and evaluate macroeconomic and development policies, designing and implementing national plans,

and investment programs and budgets, developed in a participatory manner, which include mandatory actions for government agencies and indicative ones for society in general and businesses. A series of basic laws has been drawn up for regulating various sectors of society, creating stable rules that allow public and private initiatives to flourish, including a cooperation programme between these parties with prospects for long-term development.

The structures of the government and its agencies have been redesigned in-keeping with modernizing overall governance and public management to increase the effectiveness. Decentralization has also been high on the Government's agenda.

Macroeconomic stability has been another ongoing concern. The country now has sound financial institutions governed by law and monitored by country's central bank, the Banco Nacional de Angola. There is also the Banco de Desenvolvimento de Angola (Development Bank of Angola), for the long-term financing of national production, which is going through a cycle of healthy expansion in its private banking.

The combination of these conditions, proper regulation and institutions along with macroeconomic policies and development, has enabled the country to increase by 13.4% of GDP a year despite the sharp fall of the pace of growth seen in 2009, due to the international crisis.

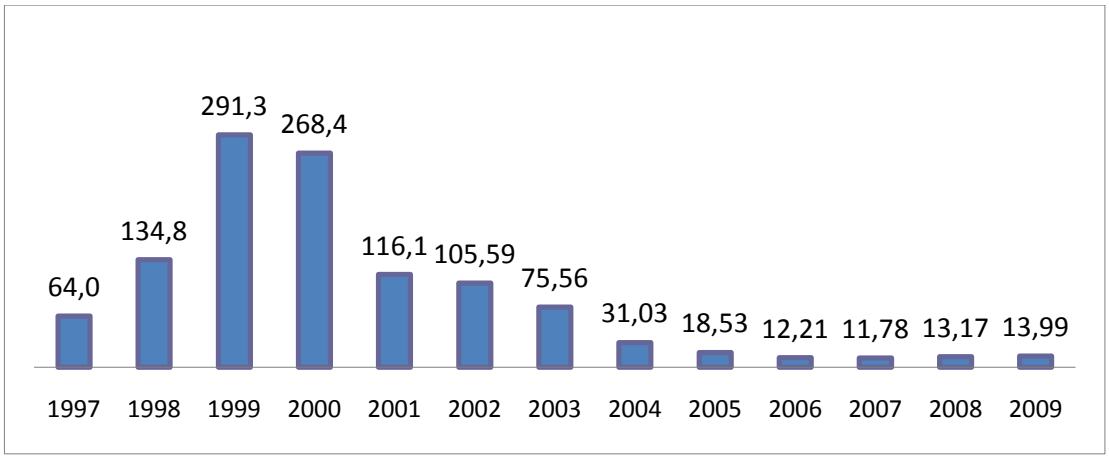
This growth occurred with a gradual improvement of living conditions for the population, which was reflected in a significant reduction in the country's poverty rate from 68% in 2001 to 36.6% in 2009. This year, the index reached 93% of the first MDG goal for 2015, 34% poor people.

Further proof of the distribution of progress seen 2002 is the gradual increase in GDP per capita, which rose from U.S. $ 643.1 in 2001 to U.S. $ 3,900 in 2009, a six-fold increase over the period; despite the fall in 2009 (GDP per capita was USD 4,667 in 2008, WB).

As for currency stability, inflation in the first decade reflects the efforts that were made to stabilize the currency, although it is still in double digits (Figure 13). Inflation in 2010 was 13%, trending downwards as a result of a realistic tax programme and a more restrictive monetary policy, conditions should reflect on the exchange rate and push inflation down even further.

The exchange rate is crucial for the country's monetary stability, due to the importance of import prices in forming the national price index.

The funding to develop the economy was hard to find, more due to the circumstances the country experienced every year after its Independence rather than due to governance. Most of these conditions were caused by the international oil market and the global economic crisis and then, more recently, by the international financial crisis.



Source: Consumer Price Index in Luanda (INE)

Figure 13 - Behaviour of inflation in Angola between 1997 and 2009

As a result, funding for national reconstruction and development policies in the first decade of this century contracted through bilateral agreements with partners who share common interests with Angola was based on guarantees associated with the production of domestic oil.

The country unsuccessfully tried for many years to reach an agreement with the International Monetary Fund on a program aimed at allowing the renegotiation of foreign debt with the Paris Club, expanding the possibilities of external funding, on better terms to finance national reconstruction and development.

The IMF agreement was finally agreed in late 2009 with the signing of a Stand-By Arrangement for a period of 27 months, including the economic and tax programme based on three pillars: strengthening tax positions, the exchange market returning to normal and a guarantee regarding the stability of the national financial sector.

This program should foster continued growth with stability and provide new opportunities for financing the economy as well as strengthening the capacity to manage and pay internal and external debt.

In regard to this last point, it is worth mentioning that a new funding strategy for the country and public debt management is being implemented in order to strengthen the current favourable aspects of the debt and to resolve unfavourable issues. A brief summary of these conditions is shown in Table 41.

Table 41 - Favourable and unfavourable aspects of the Angolan public debt profile

Favourable aspects	Unfavourable aspects
Large amount of long-term foreign public debt	Short-term internal debt profile
	Most external debt in bilateral contracts (54%)
	Difficulty in placing public securities abroad
	Existence of unsecured overdue debt from banks and suppliers

Source: Ministry of Planning

The government increased the regularization of short-term debt with banks and suppliers as of 2009 and has revised the National Budget and the Public Investment Programme, to adapt them to national funding capacity and the situation on international financial markets following the crisis, as well as seeking to sign new agreements with partner countries and expand existing agreements in more favourable terms.

It has also managed to make significant progress in normalizing the foreign exchange market and had begun rebuilding international sovereign reserves.

More important than the absolute and relative debt levels are the debt sustainability indicators, which relate to debt indicators sized to the economy and the country's ability to pay, based on GDP, exports and tax revenues, among others.

In fact, despite the briefly unfavourable position of these indicators in 2009 due to the impact of the international crisis, projections for subsequent years, carried out under the World Bank and IMF Debt Sustainability Framework (DSF), indicate a reduction in the value of debt/gross domestic product to 19.6 in 2019 and 13.1 in 2029, helping Angola be seen as an economy with moderate risk, making room for raising internal and external resources to finance the country, in better terms of cost and maturities.

Access to essential medicines

Access to essential medicines is understood in the context of the MDGs as the result of cooperation with the worldwide pharmaceutical industry, so the population has access to essential medicines at affordable prices.

The Angolan government defined the framework for essential medicines that are available through the health care network. Table 42 shows that 33.8% of households had regular access to drugs at public health centres, 32.5% in urban areas and 35.6% in rural areas, showing no significant difference in access according to where Angolans live.

The IBEP data (2008-2009) also shows that there were no significant differences depending on age or gender.

Table 42 - Percentage of households that have regular access to drugs in clinics or health centres Angola (2008-2009)

Categories		**Percentage**	
Angola		33.8	
Place of residence			
Urban	32.5%	Rural	35.6%
Schooling of head of household			
- None	35.8%	- Secondary education or more	29.6%
Primary education	35.3%	- Other or not declared	50.4%

Source: IBEP (2008-2009)

Access to new technologies

Access to new communication technologies and data transmission has become essential in terms of development, national economic productivity and business competitiveness. In addition, new technologies have a major impact on people's level of information, knowledge and culture, not to mention a host of other aspects of everyday life that are influenced by technological advances.

In Angola, the war had a disastrous effect on communication infrastructures.

Landlines in particular were virtually destroyed, and even today are difficult to reconstruct, given the amount of investment required for a modern telephone service.

There are, therefore, practically no fixed telephone lines, as shown in Table 43.

Table 43 - Proportion of households and their residents aged 15 to 74 who have landlines in Angola, according to area of residence and characteristics of the head of the household (2008-2009)

Categories	Percentage of households	Percentage of population
Angola	1.5	0.7
Place of residence		
- Urban	2.4	1.0
- Rural	0.6	0.3
Schooling of head of household		
- None	0.0	0.0
- Primary education	0.7	0.3
- Secondary education or more	3.4	1.5
- Other or not declared	3.8	1.6

Source: IBEP (2008-2009)

The data shows us that 1.5% of households had landlines. In urban areas, this proportion reached 2.4%, while in rural areas it was only 0.6%, i.e. one landline for 167 households. In Angola, only 0.7% of people in households had landlines.

79.4% of existing telephone lines were in urban areas and only 18.1% in rural areas. The higher the education level of the head of the household, the greater the likelihood of them having a landline.

Table 44 shows a better situation with mobile phones: 40.4% of households had mobile phones, in urban areas this figure was 67.5% while it was just 10.5% in rural areas.

Furthermore, 32.6% of people throughout the country had mobile phones, 52.8% in urban areas and 6.3% in rural areas.

In both cases, mobile phones per household or per user, there were marked differences between urban and rural areas.

The statistics for households or subscribers also shows that access to mobile phones grows significantly with the level of education. The proportion of people without any schooling who own a mobile phone was only 6.6%, while the proportion of people with high school degrees or more with mobiles was 60.7%, or about nine times more.

Table 44 - Percentage of households and their residents aged 15-75 in Angola with mobile phones according to area of residence and characteristics of the household (2008-2009)

Categories	Percentage of households	Percentage of population
Angola	40.4	32.6
Place of residence		
- Urban	67.5	52.8
- Rural	10.5	6.3
Schooling of head of household		
- None	7.7	6.6
- Primary education	29.7	20.0
- Secondary education or more	74.8	60.7
- Other or not declared	54.6	43.2

Source: IBEP (2008-2009)

Table 45 shows Internet access statistics approved by the IBEP (2008-2009). The numbers are very low with no proportion that is noteworthy. If, on the one hand, this may mean the country is excluded from such technology, it is also an excellent opportunity for government cooperation with the private sector to spread access to this technology. The potential benefits for the Angolan population of cooperation to expand the use of the Internet were varied, ranging from access to information to improved personal and business productivity.

Table 45 - Percentage of households and their residents aged between 15 and 74 in Angola with Internet access, according to area of residence and characteristics of the head of the household (2008-2009)

Categories	Percentage of households	Percentage of population
Angola	0.7	0.3
Place of residence		
- Urban	1.2	0.4
- Rural	0.1	0.0
Schooling of head of household		
- None	0.1	0.0
- Primary education	0.1	0.1
- Secondary education or more	1.8	0.6
- Other or not declared	0.9	0.3

Source: IBEP (2008-2009)

B) CHALLENGES

The challenges faced in the eighth MDG are initially related with the feasibility of a strategy for financing the economy and public management that maintains the downward trend of GDP relevant relationships, exports and government revenue, so to confirm the moderate risk predictions of the economy, creating sustainable conditions to finance continued national development over the long term.

This requires cooperation with national and international partners to gain access to essential medicines and communications technology, particularly the Internet. In the first case, apart from an agreement with the pharmaceutical industry, there is a logistics need to ensure stocks, handling and proper distribution of medicines to avoid waste through drug deterioration or end of validity periods.

In the second case, the initial step consists in verifying whether there are legal and institutional frameworks in the country, namely proper regulation of the communications sector, so that it can then attract international investors and national stakeholders interested in taking advantage of business opportunities in Angola.

C) POLICIES AND PROGRAMMES

In regard to financing, the main measures and ongoing programs to overcome the challenges, are to comply with the 2009 Stand-By Agreement objectives, balancing the country's domestic and foreign tax and public accounts, facilitating access to sources of multilateral financing and international banking, with maturities and costs that can be supported by the development of the Angolan economy, while it increases the domestic market for government securities and Angolan sovereign bonds.

In the case of health, apart from continuing the programme to ensure availability of essential drugs, there could also be a program designed to attract national and international investors interested in launching generics and so on, focused on the essential needs of the population.

The development strategy of public-private partnerships in Angola, or regulating markets to stimulate private investment through franchises, are two strategies that could be implemented to address the constraints of the current landline and Internet sectors.

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