

Angola



The Present Context

Angola is emerging from a 40-year-long civil war that killed one million people, uprooted a third of the population and destroyed much of its infrastructure. In spite of natural wealth in oil, gas and diamonds, it is one of the poorest countries in the world, ranking 160 on the UNDP Human Development Index. Following the 2002 peace accord, some four million internally displaced persons and more than 350,000 refugees have returned.

An estimated 700,000 people still live in areas of difficult access. Vulnerability is high: according to the WFP, there are around one million people either food insecure or in immediate need of food aid. The gradual return of IDPs and their sustainable resettlement, together with the reintegration of UNITA soldiers into civilian life

are key to the country's stability and security. The government has requested a donors' conference to help fund the reconstruction of the country. However, the engagement of donors and international financial institutions seems so far to be half-hearted.

Crisis involving: The Whole Population

Millennium Development Goals in Angola

Eradicate extreme poverty & hunger	Achieve universal primary education	Promote gender equality	Reduce child mortality	Improve maternal health	Combat HIV/AIDS, malaria etc.	Ensure environmental sustainability	Global partnership for development
On track	Slipping back

Note: Information is based on one to two specific targets for each major goal. The selection of goals and targets in the table is based principally on data availability.

Source: UNDP, Human Development Report. 2002

Main Public Health Issues and Concerns

Health status

- Life expectancy is 40 years. Infant and under-five mortality rates, estimated at 195 and 265 per 1,000 live births per year respectively, are among the world's highest. Malaria, acute respiratory and diarrhoeal diseases, tetanus and malnutrition, combined with poor access to healthcare, damaged infrastructure and lack of trained health professionals, are the main causes of mortality.
- The maternal mortality rate is estimated at about 1,700 per 100,000 live births. This extremely high rate is attributed to common pregnancy-related conditions that are not adequately treated since less than 30% of all deliveries are institutional. Malaria and hepatitis are also correlated causes of maternal mortality. The fertility rate of 6.8 is the world's second highest.
- The country is facing a high burden of communicable diseases such as malaria, tuberculosis, sleeping sickness, onchocerciasis, leprosy and diarrhoeal and respiratory diseases.
- Malaria is the first cause of morbidity and mortality and threatens the entire population, particularly children under five and pregnant women. About 35% of all cases and 70% of all deaths reported annually (estimated at 35,000) occur in under-five children.
- Between October 2004 and July 2005, the largest outbreak of Marburg haemorrhagic fever ever recorded killed 329 people out of 374 affected (CFR 88%).

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- Chronic malnutrition rates are high as 40-50%. About 45% of children under five are stunted and over 30% underweight. Outbreaks of pellagra highlight the extreme food insecurity of the most vulnerable.
- The current estimated prevalence of HIV/AIDS infection in the country is 3.9%. Percentages in border provinces with high population movement with neighbouring countries and trade such as Cunene and Uige are significantly higher, reaching 9.1% and 4.8% respectively. Angola is on the list of treatment scale-up of the WHO 3 by 5 Initiative.
- The proportion of people with piped water is 33%, with sewage system is 14%. The solid waste management – including hospital and health facilities waste – is inadequate in all the country.

Health System

- After decades of under-financing and diversion of national capacities from the social sectors, re-construction is challenging. There are substantial inequalities in resource allocation and health services coverage across the country. Only 2% of public expenditure is allocated for health.
- There has been massive infrastructure destruction (65% of peripheral health units) that calls for huge investment. Efforts have begun to rebuild infrastructures and establish health services for maternal and child care in all municipalities.
- More than 50% of public health expenditure goes to referral and central facilities; Primary Health Care is poorly developed.
- Access to health care is limited to 30 or 40% of the population and most people need to walk long distances to access them. Health service coverage depends on external support and is limited to cities and towns where the private sector has grown unregulated.
- Health care consumption is low, even in the more secure and well-resourced parts of the country.
- During the conflict, the workforce expanded and imbalances grew; 70% of doctors are concentrated in the capital; nurses and primary health care workers are in acute shortage. There is an estimated 5 physicians per 100,000 people.
- Because of insufficient financial inputs and inefficiency in the pharmaceutical area, drug scarcity has become a constant, distinctive pattern.
- There is no emergency preparedness planning.

Main Sector Priorities

The main health sector priorities include:

- Reinforcing the capacity of health system to deliver quality mother and child health services and increasing the skills of health professionals;
- Promoting integrated health programme for infant child and adolescents;
- Strengthening the capacity in developing and managing health promotion strategies;
- Strengthening the MoH capacity for surveillance and monitoring of communicable diseases and for emergency preparedness and response;
- Supporting HIV/AIDS prevention and control;
- Reinforcing health financing and social protection by strengthening management and financial systems (including information), to identify main inefficiencies and inequalities, correct them and attract additional resources;
- Training (particularly in-service) directed at restructuring, upgrading and streamlining the dilapidated workforce, a precondition to the redeployment of available staff and to the improvement of the quality of health care.

More information can be obtained from the [CE-DAT](#), a database on the human impact of complex emergencies part of the SMART initiative launched in June 2002 by a consortium of UN agencies, NGOs and academic institutions.