REPRODUCTIVE HEALTH at a GLANCE

62914

ANGOLA

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Country Context

Eight years after the end of the decades-long war in April 2002, Angola has made substantial economic and political progress. However, the country continues to face developmental challenges including reducing the dependency on oil and diversifying the economy, rebuilding its infrastructure, improving institutional capacity, governance, public financial management systems, human development indicators and the living conditions of the population. About 37 percent of the population still lives below the poverty line.[1]

Angola's large share of youth population (45 percent of the country population is younger than 15 years old[2]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth. This is especially important in a context of decelerated growth rate arising from the global recession.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[3] In Angola, the literacy rate among females ages 15 and above is 57 percent.[2] Fewer girls are enrolled in secondary schools compared to boys with a 83 percent ratio of female to male secondary enrollment.[4] Three-quarters of adult women participate in the labor force[2] that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Angola ranks 142 of 157 countries in the Gender-related Development Index.[5]

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[3]

Angola: MDG 5 Status

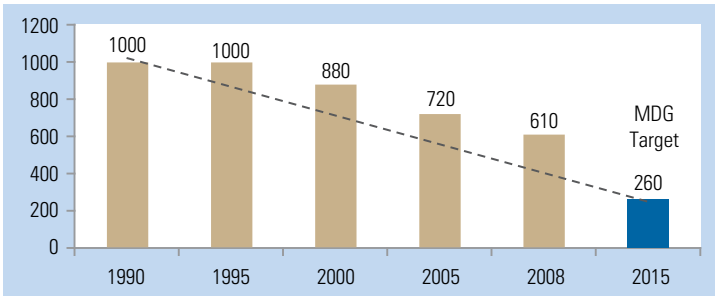
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	614
Births attended by skilled health personnel (percent)	51.8
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	6.2
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	165
Antenatal care with health personnel (percent)	79.8
Unmet need for family planning (percent)	NA

Source: Table compiled from multiple sources.
[a] The 2008–2009 DRC DHS estimated maternal mortality rate at 498.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Angola has been making progress over the past two decades on maternal health but it is not on track to achieve its 2015 targets.[6]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Angola

The Bank's new ***Country Assistance Strategy*** under preparation (P115339) is scheduled to be approved by the Bank's Executive Board on December 21, 2010.

Current Project:
P111840 AO-Municipal Health Serv Strength (FY10) ($70.8m)

- *Improved health service delivery including training of health personnel, scaling up of outreach and community health services, strengthening of obstetric care, and improvement of hospital waste management*
- *Facilitate access to child delivery services and pre-natal care through cash transfer programs*
- *Strengthen capacity for Project Management and Monitoring and Evaluation*

Pipeline Project: None

Previous Health Project:
P083180 AO-HAMSET SIL (FY05)

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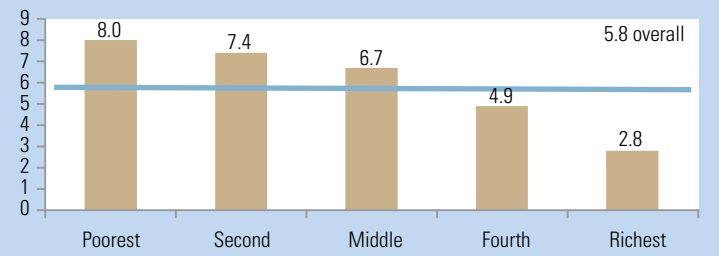
Key Challenges

High fertility

Fertility remains high, especially among the poorest. Total fertility rate (TFR) fell from 7.2 births per woman in 1990 to 5.8 in 2006(2, 7). TFR is very high at 8.0 births per woman among women in the lowest quintile in contrast to 2.8 among women in the highest wealth quintiles (Figure 2). Disparities exist between women in rural areas at 7.7 births per woman compared to 4.4 for those in urban areas, and vary by education levels at 7.8 births per woman with no education, and 2.5 with secondary education or above.[7]

Figure 2 ▪ Total fertility rate by wealth quintile



Source: Malaria Indicator Survey Final Report, Angola 2006-07.

Adolescent fertility rate is high affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[3, 8] In Angola, there are 165 reported births per 1,000 women aged 15–19 years.

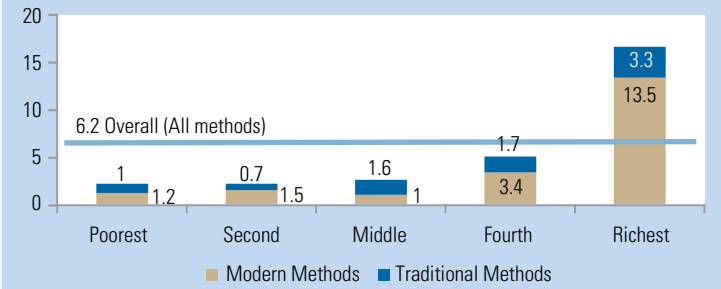
Less than a tenth of women use contraception. Current use of contraception among married women was 6 percent in 2001 and more married women use modern contraceptive methods than traditional methods (4 percent and 2 percent).[9]

The use of modern contraception methods shows important socioeconomic differences: it is 14 percent among women in the highest wealth quintile and 1 percent among those in the poorest quintile (Figure 3). Similarly, among women with no education use modern contraception is negligible as compared to 25 percent of women with tertiary education, and 1 percent for rural women versus 6 percent for urban women. There is no available data on unmet need for contraception as well as reasons why women do not use contraception.

Poor Pregnancy Outcomes

While majority of pregnant women use antenatal care, institutional deliveries are less common. Four-fifths of pregnant

Figure 3 ▪ Use of contraceptives among married women by wealth quintile

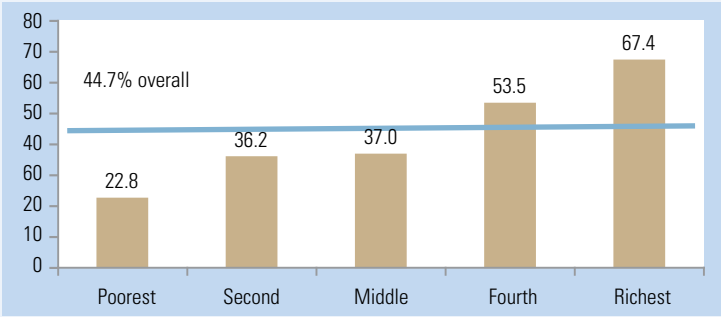


Source: MICS2 Final Report, Angola 2001.

women receive antenatal care from health personnel (doctor, nurse/midwife, or auxiliary nurse/midwife).[7] However, a smaller proportion, 47 percent deliver with the assistance of health personnel but this is up from 45 percent in 2001.[7, 9] According to the 2001 MICS2, while 67 percent of women in the wealthiest quintile delivered with skilled health personnel, only 23 percent of women in the poorest quintile obtained such assistance (Figure 4).[9] Additionally, 29 percent of women with no education delivered with skilled health personnel as compared to 82 percent of women with secondary education or higher. Further, 57 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[10]

There is no available information on women's perception on the barriers to accessing health care.

Figure 4 ▪ Birth assisted by health personnel (percentage) by wealth quintile



Source: MICS2 Final Report, Angola 2001.

Human resources for maternal health are limited with only 0.08 physicians per 1,000 population but nurses and midwives are slightly more common, at 1.35 per 1,000 population.[2]

The high maternal mortality ratio at 610 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[6]

STIs/HIV/AIDS is a growing public health concern

The HIV/AIDS prevalence is estimated at 2.1 percent which is comparatively lower than that of neighboring countries. However, the opening of borders and increased population movements could potentially lead to rapid spread of the epidemic, especially in border provinces.

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Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Increase family planning awareness and utilization through outreach campaigns and messages in the media with particular focus on vulnerable populations such as youth, the poor, and women in hard-to-reach areas. Enlist community leaders and women's groups and emphasize community-based distribution.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including longterm methods, through proper counseling which may entail training/re-training health care personnel.

Reducing maternal mortality

- Promote institutional delivery through provider incentives and possibly, implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- Target the poor and women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.
- During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children.

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Lower the incidence of HIV infections by strengthening Behavior Change Communication (BCC) programs via mass media and community outreach to raise HIV/AIDS awareness and knowledge.
- Strengthen screening and surveillance systems, particularly in border areas, to track the epidemic and ensure appropriate distribution of services

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Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

National Policies and Strategies that have Influenced Reproductive Health

2003 The Ministry of Health changed its name to Ministry of Health and Family Planning to signal the importance of reproductive health to the health agenda in Madagascar.

2003 The Government took the lead in organizing a series of stakeholder meetings and a national conference to develop a new family planning strategy. Subsequently, the Family Planning program gained recognition at the same level as the fight against HIV/AIDS and Roll Back Malaria.

2006 For the first time, Malagasy government allocated funds to purchase contraceptives. Previously, family planning efforts have depended solely on donor financing.

2008 Safe delivery kits for both normal and cesarean deliveries were introduced by the Ministry of Health at the health center/ hospital level. Deliveries thus became free-of-charge for the patient.

ANGOLA REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2007	5.8	Population, total (million)	2008	18.0
Adolescent fertility rate (births per 1,000 women ages 15–19)	2007	165	Population growth (annual %)	2008	2.6
Contraceptive prevalence (% of married women ages 15–49)	2001	6.2	Population ages 0–14 (% of total)	2008	45.3
Unmet need for contraceptives (%)	—	—	Population ages 15–64 (% of total)	2008	52.3
Median age at first birth (years) from DHS	—	—	Population ages 65 and above (% of total)	2008	2.5
Median age at marriage (years)	—	—	Age dependency ratio (% of working-age population)	2008	91.4
Mean ideal number of children for all women	—	—	Urban population (% of total)	2008	56.7
Antenatal care with health personnel (%)	2007	79.8	Mean size of households	2006/07	6
Births attended by skilled health personnel (%)	2007	51.8	GNI per capita, Atlas method (current US$)	2008	3340
Proportion of pregnant women with hemoglobin <110 g/L	2008	57.1	GDP per capita (current US$)	2008	4714
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	1040	GDP growth (annual %)	2008	13.2
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	1024	Population living below US$1.25 per day	—	—
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	880	Labor force participation rate, female (% of female population ages 15–64)	2008	76.3
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	720	Literacy rate, adult female (% of females ages 15 and above)	2008	57
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	614	Total enrollment, primary (% net)	—	—
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	260	Ratio of female to male primary enrollment (%)	2008	81.1
Infant mortality rate (per 1,000 live births)	2008	130	Ratio of female to male secondary enrollment (%)	—	—
Newborns protected against tetanus (%)	2008	79	Gender Development Index (GDI)	2008	142
DPT3 immunization coverage (% by age 1)	2008	81	Health expenditure, total (% of GDP)	2007	2.5
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	1.1	Health expenditure, public (% of GDP)	2007	2.0
Prevalence of HIV, total (% of population ages 15–49)	2007	2.1	Health expenditure per capita (current US$)	2007	85.7
Female adults with HIV (% of population ages 15+ with HIV)	2007	61.1	Physicians (per 1,000 population)	2004	0.08
Prevalence of HIV, female (% ages 15–24)	2007	0.3	Nurses and midwives (per 1,000 population)	2004	1.35

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	MICS	2006/07	8	7.4	6.7	4.9	2.8	5.8	5.2	2.9
Current use of contraception (Modern method)	MICS2	2001	1.2	1.5	1	3.4	13.5	4.5	–12.3	0.1
Current use of contraception (Any method)	MICS2	2001	2.2	2.2	2.6	5.1	16.8	6.2	–14.6	0.1
Unmet need for family planning (Total)	—	—	—	—	—	—	—	—	—	—
Births attended by skilled health personnel (percent)	MICS2	2001	22.8	36.2	37	53.5	67.4	44.7	–44.6	0.3