SUBSISTENCE NEEDS (HEALTH NUTRITION AND SHELTER)

General

Basic needs of the majority of IDP communities and resident populations are not being met (February 2002)

"Agencies estimate that only 25 percent of the basic needs of vulnerable populations, including both resident and displaced communities, are currently being met.

Acute malnutrition exists in at least eight locations, including Caconda, Cruzeiro, Cuemba, Cusse, Lau, Luena, Mussende and Sambo Samboto, and is probably present in a further three to four.

According to the Executive Committee of the Inter-Ministerial Commission, the Angolan Armed Forces and OCHA, critical needs are suspected in 60 locations in 11 provinces. Of these, 53 cannot be reached by international agencies." (UN OCHA 8 February 2002)

Populations on the move in interior regions are in "appalling" condition (November 2001)

- Tens of thousands of newly displaced persons are thought to be on the brink of starvation
- Up to 500,000 people living in areas inaccessible to international agencies are estimated to be in need - with more than 200,000 believed to be in acute distress

"Possibly the most vulnerable populations in Angola are the increasingly large numbers of families who are on the move in interior regions. Tens of thousands of newly displaced persons are estimated to be foraging for food in the bush. Credible reports indicate that the condition of these populations is appalling and that many are probably on the brink of starvation. Widows, separated children and persons with physical disabilities are highly vulnerable throughout the country, but face serious dangers during displacement. Many are unable to reach safe havens and remain abandoned in insecure areas, at constant risk of attack and abduction. In addition to these groups, about which little is known, as many as 500,000 people living in areas inaccessible to international organisations are estimated to be in need. At least 20 locations, with a combined total of more than 200,000 people, are believed to have populations in acute distress. Information on the condition of these groups is provided by newly displaced, church networks and military personnel. Reliable reports in early October indicated that populations in four to five inaccessible locations were in catastrophic condition and that at least one quarter of children in these areas were at mortal risk." (UN November 2001)

Warring parties are guilty of near-total neglect of populations in need, charges MSF (July 2001)

- Forced displacement by both parties to the conflict drives civilians to restricted areas, where the authorities then fail to provide food or health care, resulting in very high levels of malnutrition and mortality

"The warring parties to the Angolan civil war are turning blind eyes to the obvious, serious, and often acute humanitarian needs of the Angolan people. Both the Government and the UNITA rebel movement are guilty of this negligence. The medical and nutritional emergencies that MSF encounters due to its projects in the field are not just a logic consequence of the ongoing war. To a large extent they are caused by the near-total neglect towards populations, the disrespect of international humanitarian law, and the military strategies of the parties to the conflict.
The underlying causes for the emergencies include:

The near absence of governmental response to emergencies in areas under its control, resulting in very high levels of malnutrition and mortality.

Forced displacement caused by military strategies applied by both parties, which drive large populations from their land and then pin them down in restricted areas, where the authorities then fail to provide food or health care.

The inaccessibility, due to insecurity and the incapacity to negotiate, with both parties, access for humanitarian assistance, of some areas of major concern for international humanitarian organizations." (MSF 2 July 2001)

Statistics on the status of children (2001-2002)

- In 2001, UNICEF and local partner carry out first nationwide survey in five years
- Results reveal 'catastrophic' situation among Angolan women and children

"Throughout 2001, UNICEF has been supporting the Angolan National Institute of Statistics (INE) in conducting a Multiple Indicator Cluster Survey (MICS), the first nation-wide survey conducted in Angola since 1996. Although carried out in accessible areas only, recently released survey results are striking and reveal a catastrophic situation among Angolan children and women. The under-five mortality rate is 250 per 1,000 live births, with wide geographical disparities from 192 to 315, meaning that every year over 155,000 children under five years of age die. This translates into 18 children dying every hour. The MICS also found that 45.2% of children suffer from stunting, illustrating the long-term negative effect of the conflict on the healthy growth of children. Immunization coverage remains very low with only 26.6% of 1-year-old children fully immunized against measles, polio, BCG, and DPT. The MICS also indicates that among children 0 to 14 years of age, there are some 750,000 orphans of either one or both parents that are being cared for in households. One of the most worrying findings of the MICS is the very low level of knowledge about HIV/AIDS, with only 8% of women having sufficient knowledge of HIV prevention and transmission." (UNICEF, 29 May 2002)

"Thirty percent of all children die before reaching the age of five. The under-five mortality rate is the second highest in the world, with one child dying every three minutes, corresponding to 20 per hour and 480 per day.

Forty percent of the children who do survive, die before 40.

Nineteen percent of children are born with a low birth-weight, 53 percent are stunted and 42 percent are severely underweight.

An estimated 100,000 children have been separated from their families as a result of war.

Credible evidence indicates that child soldiers are being forced to fight." (UN OCHA 8 February 2002)

Food and Nutrition

MSF warns of a severely malnourished 'dying population' in newly accessible areas of Angola (April 2002)

- MSF finds thousands of sick and starving people in some 30 'grey zones' which had for years been inaccessible to humanitarian organizations
- Mortality and malnutrition levels are well above emergency thresholds in areas accessed
- In Northern Huambo province, the global malnutrition rate is 18 percent, and is the main cause of death
- International aid is slow to arrive in newly accessible areas

"Over the last few weeks, teams from the international medical aid agency Médecins Sans Frontières (MSF) have come across thousands of starving and sick people, who have been stuck in those regions of Angola to which humanitarian access has been denied for many years. Thousand of civilians have been trapped in some 30 of these so-called 'grey zones', without any assistance from relief agencies or the UN.

These people have been caught up in a series of fierce wars, and many have been forced from their homes, often because their villages and homes have been destroyed. The mines, attacks and retaliations have prevented them from cultivating their crops, leaving the population destitute and extremely vulnerable.

The consequences are dramatic. Thanks to the cease-fire which has recently been agreed between government forces and UNITA, MSF teams have finally been able to access areas previously closed to us. One team assessed the situation in Bunjei, an area situated 116 km from Caala in the south of the country (Huila Province). They found extremely high mortality rates there.

Thierry Allfort-Duverger led the assessment team: 'We counted 14 deaths per day over a population of around 14,000 in Bunjei. We found more than 1,050 freshly dug graves. Bunjei is a ghost town where displaced and destitute people have been settling since last September.'

Malnutrition levels in Bunjei were found to be well above the emergency threshold. 30% of the children examined were severely malnourished and have had to be admitted to emergency therapeutic feeding centres. MSF has also opened a nutritional centre for children suffering from moderate malnutrition and has started distributing food and drinking water to 3,500 children below the age of 10. In addition, there are 900 severely malnourished children in the emergency feeding centre in Caala city.

A second MSF assessment showed an equally alarming situation in Chilembo, south of Huambo. A basic nutritional survey of 1,219 children showed that 42% of them are malnourished with 10% suffering from severe malnutrition. An emergency therapeutic feeding centre and a 'soup kitchen' are being set up for the 6,000 uprooted people in the area.

The levels of malnutrition in these two areas are extremely worrying and require an urgent general food distribution. MSF is continuing its assessments of the newly-accessible areas and is very concerned that the situation may be equally bad elsewhere. If this is the case, significant humanitarian assistance will be required. MSF itself has tripled the size of its teams in Angola to cope with the need and has set up an air bridge to bring in the necessary supplies." (MSF, 24 April 2002)

"A nutritional survey done by Epicentre among 15,000 people in Chiteta in Northern Huambo province of Angola between 10 and 14 June confirms a serious nutritional crisis. 700 severely malnourished children are being treated in MSF's Therapeutic Feeding Centre in Bailundo.

One in six children is malnourished, and malnutrition is the main cause of death in this region. The rate of global malnutrition is 18%, and the severe malnutrition rate of 5% among children-under-5. Yet there is still no guarantee that enough food is being distributed to this population.

This is just the latest indication of the scale of the emergency in Angola, where international relief has barely started to reach hundreds of thousands of people who were deprived of it during the civil war that ended in April.

The survey showed that the overall mortality rate for the first 6 months of this year (January 1 - June 12th 2002) was 2.3/per 10 000/ per day. This is four times the normal crude mortality rate, and twice the level that signifies an emergency.

Three-quarters of deaths were children under five years old. Overall mortality rates among children under 5 was of 5,7/10 000 per day: 2.5 times the emergency threshold, and five times the normal mortality rate for children under 5.

Last month MSF opened a therapeutic feeding centre in Bailundo, in northern Huambo province; this feeding centre is also assisting malnourished people gathered in Chiteta, who are taken to Bailundo by MSF mobile medical teams. More than 700 severely malnourished children are currently being treated by in Bailundo therapeutic feeding centre." (MSF, 27 June 2002)

***Click here* for MSF map showing malnutrition levels in various provinces of Angola (6 May 2002)**

Locations with hight concentrations of newly arrived IDPs show alarming levels of malnutrition (April 2002)

- Assessments in seven provinces in April 2002 all show very high levels of malnutrition, particularly in locations with influxes of IDPs
- One rapid screening of under-fives in Chipindo, Huila province, revealed a severe malnutrition rate of 64 percent
- Therapeutic and supplementary feeding centres are overcrowded and under-resourced

"High levels of malnutrition were reported in a number of locations during April, particularly in areas where large numbers of malnourished IDPs continued to arrive. In hard-hit locations, including Camacupa, Caála, Luena and Negage, the capacity of feeding centres was severely strained. The Rapid Assessment of Critical Needs indicated that several locations, including Bunjei, Sanza Pombo, Chilembo and Chipindo, urgently require food assistance to malnourished populations.

In Bié Province, an assessment mission to Chitembo revealed global and severe malnutrition rates of 25.9 and 8.5 percent, respectively. More than 45 malnourished children were transported and admitted to the feeding centres in Kuito. In Cuemba, global and severemalnutrition rates of 22 and 6 percent, respectively, were found. A screening of new IDPs in Kuito indicated global malnutrition rates of 4.9 percent and 7.1 percent for adults and children, respectively. In Camacupa, the capacity of feedings centres was expanded from 400 to 650 persons to respond to the continual arrival of displaced persons in the municipality.

In Huambo Province, a nutritional survey of 900 children in Ekunha indicated a global and severe malnutrition rates of 8.9 and 1.4 percent, respectively. During the Rapid Assessment of Critical Needs in Katchiungo, Tchicala Tcholohanga and Londuimbali, the results of mid - to upper-arm circumference (MUAC) screenings indicated a high proportion of severely malnourished children. A general food distribution in Tchilembo began as a result of the serious nutritional situation during recent months.

In Huíla Province, inter-agency teams confirmed that health and nutritional conditions among the 14,000 persons in Bunjei are critical. A rapid nutritional screening indicated global and sever malnutrition rates of 26 and nine percent, respectively. Registration for an emergency general food distribution was carried out in Bunjei to address the nutritional situation of more than 9,000 people. Severely malnourished children from Bunjei continue to be referred to feeding centres in Caála. A critical nutritional situation was also found during the Rapid Assessment of Critical Needs in Chipindo. A rapid screening indicated a severe malnutrition rate of 64 percent among children under five. More than 80 percent of the population, including adults, elderly and pregnant women, is moderately malnourished.

In Kuando Kubango Province, 74 malnourished individuals were transported from the Soba Matias quartering are to the therapeutic feeding centre (TFC) in Menongue.
In Kuanza Norte Province, preliminary results from a nutritional screening during the Rapid Assessment of Critical Needs in Samba Caju indicated a serious nutritional situation for more than 760 newly arrived IDPs, with moderate and severe malnutrition reported as 10 and 7.9 percent, respectively. The assessment team reported ten percent moderate malnutrition in Camabatela.

In Malanje Province, attendance at therapeutic feeding centres increased as a result of the arrival of new displaced persons in poor nutritional condition. TFCs remain over-crowded, despite the construction of two new centres in Malanje town.

In Moxico Province, overall attendance at the supplementary and therapeutic feeding centres increased by more than 70 percent. During the second and third week April, the number of patients admitted to the TFCs increased from 248 to 305, with an average of 87 new admissions per week. As a result of overcrowded conditions in the existing TFC, new patients were admitted to a new centre still under construction. During the last two weeks of April, approximately 90 percent of the children receiving therapeutic feeding were displaced and humanitarian partners remain concerned about increasing cases of malnutrition among new arrivals.

In Uíge Province, nutritional screenings during the Rapid Assessment of Critical Needs in Sanza Pombo indicated emergency levels of malnutrition. Among newly displaced populations, global and severe malnutrition rates were recorded at 77 and 56.5 percent, respectively. Resident populations appear to be more stable, with severe and moderate malnutrition rates of 3.5 and 7.5 percent, respectively. Humanitarian partners are making plans to urgently distribute food assistance. Partners reported that the nutritional situation at the Uíge SFC has gradually improved during the past few months. In Negage, the capacity of the SFC continues to be strained, primarily due to influxes of malnourished persons from Sanza Pombo." (UN OCHA, 30 April 2002)

Displacement remains one of the primary causes of food insecurity (November 2001)

- One tenth of all Angolans rely on external food assistance
- The majority of displaced populations do not have access to sufficient quantities of quality agricultural land

"One tenth of all Angolans depend on external food assistance to survive and an estimated 30 percent of the population is expected to experience food insecurity and hunger during the coming year. Instability, displacement, failed harvests and dysfunctional market systems remain the primary causes of food insecurity. In addition, limitations on the free movement of personnel and goods continue to raise the costs of basic commodities and reduce the amount of food available for sale. The situation is most acute in locations where persistent insecurity undermines livelihood strategies and where coping strategies are under severe stress or have collapsed.

Although efforts have been made to promote self-reliance, the majority of displaced populations still do not have access to sufficient quantities of quality agricultural land. In addition, adverse climatic conditions in 2001, including late rains and irregular or excessive rainfall, reduced overall productivity in some areas. Poor soil fertility lowered yields of key crops including maize, beans, peanuts, millet and sorghum. As a result, post-harvest food stocks are insufficient to meet requirements until the next harvest and large numbers of families in hard-hit areas have already been forced to reduce consumption to one meal per day." (UN November 2001)

Recurrent pellagra epidemic in Kuito (2001)

- Pellagra is a disease caused by poor diet, that contributes to death from other illnesses
- The population of Kuito is in nutritional crisis, with a continued high mortality rate for over three years

"Pellagra is a disease caused by consumption of a diet of low quality. There are no other causal factors involved except dietary deficiency of niacin, pyridoxine, riboflavin and tryptophan. For the past three years, there has been an annual epidemic of pellagra in the Kuito area of Angola.

The prevalence of pellagra is about 10% in the IDP camps around Kuito and about 30% in Camacupa. There do not appear to be substantial numbers of people with niacin deficient diarrhoea or nervous system complaints without skin lesions in Kuito, although the signs are more advanced in Camacupa where diarrhoea seems to be a feature. It is unlikely that the pellagra is a dominant attributable and direct cause of mortality, although it almost certainly contributes to mortality ascribed to other illnesses.

The pellagra patients are of normal weight or are overweight. This is because the nutrients involved give rise to a type I deficiency which is not associated with loss of body weight (wasting) rather than a type II deficiency which is characterised by stunting and wasting.

The population is in nutritional crisis with a continued high mortality rate for over three years; this has recently increased to crisis proportions. Although nutritional deficiencies underlie this mortality it is not reflected in the rate of wasting (global malnutrition rate) as the dominant type of micronutrient deficiency does not directly give rise to wasting: it does, however, cause severe illness including both pellagra and kwashiorkor, imunoincompetence and death; including death, rather than recovery from, infectious disease.

A major proportion of the population is entirely dependent upon humanitarian aid. Almost 60% of the population receives humanitarian aid and over two fifths of all food eaten in the area is flown in by WFP. Without this sustained effort the population would starve.
The widespread deficiencies reached a peak several months after gaps in the WFP pipeline that led to the food actually distributed having a niacin content lower than that known to cause overt clinical pellagra in otherwise healthy experimental subjects. The choice of foodstuffs to fly into Kuito has been increasingly confined to maize cereal. This coincided with the increased mortality, severe malnutrition becoming the major cause of death and kwashiorkor being the dominant form of severe malnutrition. It is critical to take steps to improve the quality of the diet that is eaten in Kuito and surrounding area." (Professor Michael Holden, FANTA project, August 2001)

Health

High morbidity and mortality rates particularly in areas with influxes of IDPs (April 2002)

- All locations assessed following April 2002 ceasefire urgently require basic health care assistance
- Main causes of death include water-borne disease, malaria, diarroeha and measles
- Aid agencies fear increase of tubercolosis patients among IDPs referred to nutritional centres

"Morbidity and mortality rates remained high in most provinces, particularly in areas receiving influxes of IDPs. Initial findings from the Rapid Assessment of Critical Needs indicate that all locations assessed urgently require basic health care assistance, including medical supplies, essential medicines, staff and repaired infrastructure.

In Benguela Province, humanitarian partners in Canjala, approximately 90 km north of Lobito, reported an increase in the number of deaths from 3-4 to 7-8 per day, particularly among malnourished IDP children and elderly. The main cause of death is water-borne disease. Provincial authorities and
agencies will provide essential medicines and reinforce the two existing community kitchens.

In Bié Province, an assessment conducted in mid April in Chitembo indicated that mortality levels are high, with crude and under five mortality rates recorded at 5.1 deaths per 10,000 persons per day and 5.5 deaths per 10,000 children per day, respectively.**2** Less than 45 percent of the screened children under five have been vaccinated against measles. Health facilities lack basic medical supplies and medicines, personnel and water and sanitation.

In Cunene Province, provincial authorities report that morbidity and mortality rates remain high, with malaria and diarrhoea reported as the primary causes of death. The incidence of measles and meningitis has decreased due to recent vaccination campaigns in the most affected municipalities, including Cuvelai and Namacunde.

In Huambo Province, a survey conducted in Ekunha indicated crude and under five mortality rates of 0.5 deaths per 10,000 persons per day and 1.2 deaths per 10,000 children per day, respectively.**3** The primary causes of death among children include malaria and measles.

In Kuanza Norte Province, preliminary results from the Rapid Assessment of Critical Needs indicated a crude mortality rate of 3.8 deaths per 10,000 persons per day among resident and displaced populations in Samba Caju.
In Kuanza Sul Province, humanitarian organisations report that new arrivals from Chimoma and Khimbungo locations are in poor health and nutritional state.

In Lunda Sul Province, IDPs arriving in Saurimo report that at least four persons are dying per day in Xassengue and Cucumbi communes in Cacolo Municipality, due to food insecurity and lack of assistance to soldiers and families moving to quartering areas.

In Moxico Province, mortality rates in Muacanhica and Muachimbo camps remain high, particularly among populations arriving from Lussi, due to the poor health status of new arrivals and insufficient capacity to respond to growing health needs. Humanitarian partners reported 33 deaths in Muacanica camp during April and a crude mortality rate of 1.45 per 10,000 persons per day. The incidence of malnutrition and skin diseases is high among arrivals from Cangumbe, Bundas and Muangai. In Luena, three suspected cases of tuberculosis have been reported in the therapeutic feeding centre.

Organisations fear an increase of tuberculosis patients among displaced persons referred to nutritional centres and have recommended improved monitoring. Vaccination campaigns reached approximately

102,000 children in the municipality of Moxico, Leua, Camanongue, Cazombo, Lumbala Ngiumbo, Luau and Kuembo (Bié Province)." (UN OCHA, 30 April 2002)

WHO finds critical health and nutrition situation in Malange Province (April 2002)

- Newly arrived populations in Malange in 'very critical' condition, with high incidence of kwashiorkor
- Large numbers of severely malnourished are still expected to arrive in Malange
- WHO reports that malaria and malnutrition are the main causes of death in the province

"Dr Pier Paolo Balladelli reported as very critical the conditions of newly arrived populations to Malange, after the peace agreement between FAA and UNITA was signed on 4 April 2002. Cases of 'Kwashiorkor', a syndrome due to acute malnutrition with bilateral edemas, are reported on a daily basis. The Nutritional Feeding Centre of Malange managed by MSF is now running at full capacity with 45 children assisted at present, the double, if compared to its target of 25 children. Another Centre was implemented by MSF in Cangandala.

'Many people with severe malnutrition – stressed the WHO Representative – are still in the way, coming from the previously held areas by UNITA. People are walking two days to reach Malange town seeking for assistance.'
[…]

Dr Balladelli in the meeting with the Governor, said that still Malaria and malnutrition were the killers number one, but HIV/AIDS, Tuberculosis, Vaccine Preventable Diseases, Sleeping Sickness and Respiratory diseases are also contributing to the tremendous burden of diseases assessed in the Malange Province. The high Maternal Mortality also needs to be addressed as a matter of priority." (WHO, 17 April 2002)

National health system unable to meet the needs of internally displaced persons and other at-risk populations (2001)

- Health care non-existent or inaccessible for majority of population
- Potential for epidemics in urban areas and IDP camps reamins high

"The health situation in Angola continues to worsen. Three decades of violence has destroyed water and sanitation systems throughout the country. Health care services are nonexistent or inaccessible for the majority of the population. IDPs are moving into already overcrowded urban and semi-urban areas without functioning health infrastructures. As a result, the potential for epidemics in urban areas and IDP camps remains high. Malaria, tuberculosis, measles, and diarrheal diseases are among the most common ailments of Angolans. In FY 2000, recurrent epidemics of polio and meningitis were reported. Immunization coverage is generally low in Angola." (USAID 2 April 2001)

"19. The [UN Inter-Agency] assessment [of April 2000] confirmed that the health system in Angola was unable to meet the needs of at-risk populations, including the displaced. None of the hospitals visited during the assessment had sufficient essential medicines. All were found to be understaffed, underfunded and in need of basic equipment. Throughout the country, there were shortages of both general and trained medical personnel and in several locations staff had not received salaries for a number of months. The conditions of hospitals and health posts varied. In some cases, buildings were adequate, while in others,

roofs were in need of repair. More than 50 per cent of the buildings lacked a regular supply of potable water and many had inadequate sanitary facilities.

20. Malaria, diarrhoea, tuberculosis and upper respiratory track infections were reported in the majority of locations visited. Measles and polio were reported in a few locations. Other diseases include meningitis and sleeping sickness. Suspected cases of HIV have been recorded, though it is suggested that this disease is significantly underreported. Tuberculosis and diarrhoea were prevalent in transit centres where severe overcrowding, appalling sanitation and extreme destitution had put the displaced at risk of infection. Skin diseases were also widespread.

21. Vaccinations were incomplete in many locations. Large numbers of children under five had received only one dose of a multi-dose vaccine or none at all. Coverage for children over five was even more limited. In all locations visited, delivery practices were rudimentary. Although problems with birthing are common, there were virtually no delivery or post-delivery facilities in either hospitals or health posts.

22. In some areas with a high concentration of mine victims, for example Andulo, Negage and Maquela do Zombo, the medical services were found to be inadequate. There were no appropriate evacuation methods and local health facilities lacked the necessary blood and surgical equipment to treat mine victims. Prostheses are available at only five centres in the country." (CHR 25 January 2001, paras. 19-22)

Displaced are particularly vulnerable to reproductive health and sexually transmitted diseases (2000-2001)

- Maternal and infant mortality rates are the worst in Africa
- Internally displaced women at higher risk than others of dying from pregnancy-related causes
- HIV/STDs threaten the health of displaced women and children due to lack of protection and awareness
- International agencies lack the resources to improve the situation of reproductive health

"Angola falls under the category of a chronic emergency, yet even the most basic minimum standards for reproductive health (RH) services are not being met. Even the many NGOs and UN agencies that signed on to the Inter-Agency Field Manual for Reproductive Health in Emergency Situations [WHO, UNFPA, UNHCR] are not coming close to meeting the minimum standards they committed to by signing on to this document. This is due not so much to a lack of interest or concern, but a lack of resources. And in some cases this is due to the pervading attitude of international health agencies that reproductive health services fall outside of emergency lifesaving interventions.

Although the needs are great in both the IDP and local communities, we were told that IDPs did have special needs and considerations. In the four provinces that we visited, health workers said that awareness of reproductive health issues is lower among IDPs than in the local communities. We were also told that IDPs often wait too long to access services. The reasons for this are unclear. We did hear complaints that IDPs were not treated well at certain health facilities, and that they lack faith in the health system. We also heard that some health workers demand payment from patients as a way to supplement meager salaries, and that IDPs are less likely to be able to pay for the services. At some hospital maternities we visited, the IDPs were sleeping on the floor because they did not have sheets to put on the mattresses.
[...]
Angola has one of the highest maternal mortality ratios in the world, estimated at 1,500 per 100,000 compared to bordering Namibia at 370 per 100,000 and Canada at 5 per 100,000. This should not be surprising since fertility rates are high, use of family planning is low, ante-natal care is not widely

available, and many women do not have access to emergency obstetric services. UNFPA-Angola produced a report in June 1999 titled *The Demographic Profile and the Reproductive Health of the IDPs.* The findings of this report are based on interviews with 1,422 IDPs in Huila, Benguela, Malanje and Zaire provinces. This study reportes that the average number of children per woman interviewed was 8.6. The infant mortality rate is 125 per 1,000 in Angola, whereas in Canada, for instance, it is 5.5 per 1,0000." (Women's Commission February 2001, p. 8)

"Of serious concern is the growing prevalence of sexually transmitted diseases, including HIV/AIDS. For example, the number of reported HIV/AIDS cases among pregnant women in Luanda city has increased four-fold in the last ten years from 0.9 percent in 1989 to 3.4 percent in 1999. National data indicates that HIV/AIDS is spreading at an alarming rate, affecting both women and men and jeopardising the rehabilitation of the country. Displaced populations are particularly vulnerable due to the lack of protection and HIV/AIDS awareness, poor health care services and limited opportunities to generate income." (UN November 2000, Humanitarian Context)

"Prevention of HIV/AIDS infection: HIV/AIDS cases are currently estimated as being low in Angola but are increasing due to uncontrolled migrations through borders with neighbouring countries, massive internal displacements and the presence of large groups of soldiers known to engage in risky sexual behaviour. Poverty is also leading to ever-greater numbers of occasional sexual workers. Furthermore, with promiscuity, poor standards of living, constant migration of husbands in the neighbouring countries (with extremely high rates), the risk of contracting STDs and HIV/AIDS is higher among women of [child bearing age] and adolescents.
[...]
The maternal and infant mortality rates are the worst in Africa, estimated in 1998 at 1,854/100,000 and 166/1,000 live births, respectively. The estimated national contraceptive prevalence rate is very low (3 percent), and only 19 percent of women have assisted deliveries. IDP women are known to be at higher risk of dying from pregnancy related causes due to lack of access to health services and life in stressful conditions. A survey conducted by UNFPA and the implementing agencies in 1999 with 710 men and women in IDP camps and periurban areas of Matala, Chibia, Lubango, Lobito, Baia Farta and Benguela indicated that there is: (1) very poor attendance of pregnant women; (2) a lack of knowledge about child spacing and sexuality issues, among men and women; (3) little use of family planning methods; (4) little knowledge about STDs/AIDS; and, (5) an overall expectation of large family size. With regard to questions about forced sex, 19 percent of women indicated they knew of women who were forced to have sex, while 11.4 percent of men affirmed that they knew of men who were forced to have sex." (UN 30 November 1999, pp. 42, 50)

For a full report on reproductive health among IDPs in Angola with detailed information on the situations in Bie, Malanje, Moxico, Huambo and Luanda, see the Women's Commission assessment of February 2001 available from the Women's Commission or the Global IDP Project.

Children are especially vulnerable to psychological stress from exposure to conflict (February 2001)

"According to the Christian Children's Fund (CCF), Angola's children are especially vulnerable to psychological stress from exposure to ongoing violent conflict. CCF estimates that 82% of children in IDP camps have come under fire, more than 66% say they have seen people killed or tortured and 24% have lost a limb. Therefore, psychological trauma is a significant issue among IDP youth (and surely IDPs of all ages) and one requiring much greater attention." (Women's Commission February 2001, p. 13)

Water and sanitation

Vast majority of displaced communities use contaminated water sources (November 2001)

- 90 percent of displaced communities use contaminated water sources, resulting in potentially fatal water-borne diseases
- Problem is most acute in overcrowded camps and transit centres

"At least 60 percent of the general population and 90 percent of displaced communities use contaminated water sources. Water systems in provincial and municipal centres are over-loaded, and in many locations, no longer functional. Problems with water quality and quantity are most acute in areas where large numbers of displaced persons are living in overcrowded camps and transit centres. Lack of hygiene awareness is a major factor leading to persistently high levels of diarrhoea. Water-related diseases continue to be one of the most common causes of morbidity across the country and a frequent cause of under-five mortality. In the majority of IDP areas, the number of latrines is inadequate for population densities. An estimated 75 percent of latrines in these areas have reached capacity levels. The shortage and over-use of latrines, particularly in highly populated areas, continues to contaminate watercourses, contributing further to the pollution of community water sources." (UN November 2001)

Shelter and non-food items

More than 84,000 newly displaced persons in various locations are in urgent need of shelter and essential survival items (March 2002)

"More than 84,000 newly displaced persons in Bocoio, Caconda, Camacupa, Cruzeiro, Huambo, Kuito, Luena, Matala and Wako Kungo are in urgent need of essential survival items and appropriate shelter. With the exception of IDPs in Kuito, where water and sanitation interventions are ongoing, these same populations lack access to basic water and sanitation. A direct correlation exists between inadequate shelter, contaminated water sources, unhygienic faecal disposal and high levels of malnutrition, morbidity and mortality in these areas. Urgent funding is required to reinforce the pipeline for non-food items. Support is also required to increase agency capacity for transporting essential non-food items, shelter materials and water and sanitation equipment to critical areas." (UN OCHA 7 March 2002)

Thousands of IDPs remain in sub-standard transit centres (December 2001)

- Approximately 17,500 IDPs continue to live in sub-standard conditions in 13 transit centres in nine provinces

"Since April 2000, 35 transit centres have been closed. Approximately 17,500 IDPs continue to live in sub-standard conditions in 13 transit centres in the Provinces of Benguela, Bié, Huambo, Huíla, Kuanza Sul, Luanda, Malanje and Uíge. During December, new transit centres were opened in Kuito (Bié Province) to accommodate the continuous influx of new IDPs. Despite attempts to close transit centres and warehouses in Benguela and Lobito (Benguela Province), Bongo and Longonjo (Huambo Province) and Caconda (Huíla Province) by the end of 2001, persistent insecurity, constant new arrivals and inadequate registration procedures have forced these centres to remain open." (UN OCHA 31 December 2001)

Life in tents or warehouses embarrassing for people accustomed to having their own homes (2001)

Excerpt taken from Andrade study conducted in 1996-1997:

"Most respondents considered that adapting to the new physical environment had been difficult and slow. Previously respondents had been used to having their own houses and working their fields, thus guaranteeing subsistence for themselves and their families: after displacement many did not have access to their own houses and fields.

Life in tents or warehouses was embarrassing for people who were accustomed to having their own house: they had to live in a group and sleep alongside others. Some people built houses, but in Malanje city displaced people found it difficult to make bricks because they were used to living in houses of wattle and daub in rural areas. Some displaced people (most of them from Cuale, Malanje) rented houses, either from local residents or from displaced people who had come in previous decades. This contributed to the marked feeling of insecurity." (Andrade 2001, sect. 5.1)

For more information on the feelings of IDPs during period of displacement, see Filomena Andrade report available from Development Workshop - Angola.

Internally displaced persons live in crowded camps, in derelict buildings, and in and underneath train carriages (1998-2000)

- Displaced populations generally live in crowded mud house shanty towns
- Huts are clustered together in areas of about 10,000 houses
- In transit centre in Caala, displaced living in and under train carriages
- Other displaced persons reside in derelict buildings

"During his [the Representative of the United Nations Secretary-General on Internally Displaced Persons, Dr. Francis M. Deng] visit to the province of Huambo, the Representative saw both the problems and prospects facing the internally displaced. In a transit centre in the town of Caala, the internally displaced were found to be living in appalling conditions, in a derelict building and in and underneath two train carriages. The Representative was struck by the overriding sense of despair and depression amongst the displaced." (UNHCHR 10 November 2000, para. 8)

"Q. It's estimated that some 2 million Angolans are displaced within the country, many of them living in camps for internally displaced people (IDPs). Describe an IDP camp.

A. There are thousands of predominantly mud houses spread all over once-cultivated hillsides. The houses are mostly arranged in lines and, as more IDPs arrive, they become burgeoning neighborhoods with little space. There are pathways. The houses have grass roofs, some are covered by plastic. They are one room and very close together – about four feet between houses. They are usually clustered, in areas of about 10,000 houses. The hillsides, which used to be all green with vegetation, are now covered with huts. From a distance, they look like the tops of igloos. All camps have open areas, all defoilated, for football, or where there are clinics and a meeting hall. Some people have been there for seven years, but most camps have been built since February 1999." (CARE 11 September 2000, Question 3)

"In the inland cities [in the areas controlled by the government,] many IDPs live in abandoned buildings or with friends or relatives. Many of the displaced on the coast live in shanties thrown up on the outskirts of towns, or in camps set up away from the cities themselves.
[...]

In the capital of Moxico province, Luena, a town of 150,000, some 60,000 people are estimated to be internally displaced from other areas of Angola. They have taken over several municipal buildings, including the old seminary, cinema, museum and railway station. The World Food Programme distributes some food and health care. The living conditions of the people are miserable, their motivation to return home poor; they remain socially isolated in ghettoized buildings in the town centre."(Vines 1998, p. 92)