Linking Policy to Programming

Situational analysis on young key populations' sexual and reproductive health and rights in Angola

This brief presents the findings of a situational analysis of the sexual and reproductive health and rights (SRHR) of young key populations (YKPs)[1] in Angola, undertaken by HEARD, University of KwaZulu-Natal. The analysis was part of a larger, multi-country project (2017-2020) which seeks to strengthen the legal and policy environments for YKPs and improve their SRHR in Southern Africa[2]. The analysis brought together existing and new data in order to capture the political, legislative, socio-economic and socio-cultural issues that affect the SRHR of YKPs. Data collection included qualitative and quantitative data from published and grey literature and existing data sets, as well as primary data obtained through key informant interviews with actors from government, international organisations or NGOs working with young people on issues of SRHR.

Key Findings

The Socio-Economic and Legal Context

Despite Angola's official status as a middle-income country due to its vast oil revenues, many Angolans still suffer from poverty. Falling oil revenues since 2014 have led to decreases in GDP and have worsened poverty and inequality in the country. In 2016, it was estimated that 40.1% of the population were living in poverty, and that the poverty rate was increasing, with prediction of it rising to 44.1% by 2021. Poverty is much higher in rural than in urban areas of the country [1]. Rural poverty is estimated at 57% compared to urban poverty levels of 19% [2]. Youth unemployment is estimated at around 26% [3]. The informal sector is reckoned to be the largest employer of people though this has not been accurately measured.

The impacts of the long civil war are still being felt in Angola and have a particular impact on young people. "Because of the 27-year conflict, almost two generations of youth in Angola have missed important opportunities to enter adulthood successfully. The war caused long-term disruptions to the social systems and infrastructure that typically supported youth. Among these, education was definitely the most affected sector. Moreover, the war produced a context of insecurity that caused youth to avoid combat by migrating, especially to urban areas, or pulled them into it as soldiers or servants for adult combatants" [4].

The long-term effects of the war on the rural economy mean that many young people continue to migrate to urban areas to seek economic opportunities. Rapid urbanization has led to rising urban unemployment and pressure on infrastructures and services such as housing, health services and education in cities. Many young people have adapted by seeking refuge on Angola's urban streets, engaging in all sorts of economic – often illegal and dangerous – activities and have had to postpone education and take on greater responsibilities within their families.

There is a general lack of state investment in public services, with education and health, for example, gaining only around 3% of the national budget. The public health system in Angola is weak, with an estimated 40% of the population having access to high quality health services. Public health services, from primary care to specialized services, are available at no cost, subject to availability of human, technical and financial resources. However, the public system suffers from shortages of doctors, medicines, nurses, primary health care workers, as well as inadequate training and medicines. As a result, access to healthcare

services and to medicines for the majority of the population is limited. Despite continuing investment in resources, provision of public health care continues to be severely constrained by lack of staff, medicines, and equipment but there are provincial variations in the severity of the constraints [5]. The best quality health services are found in major cities. But those who can afford to usually use private health service providers.

Access to health care is particularly problematic for women. Seven in ten women in Angola report at least one problem in accessing health care. Sixty-three percent of women had difficulties getting money for advice or treatment, and 52% had problems with the distance to the health facility.

The 2015-16 multiple indicator and health survey included some information on the accessibility of health services amongst adolescents. 72% of 15-19 year old adolescents reported that access to health services was difficult. The reasons included lack of authorization [from parents] (34%), lack of money for counselling or treatment (63.1%), distance to a health unit (52.1%), and not wanting to go alone (38.3%) [6].

Low investment in education means that many young people, especially in rural areas, do not have access to schools beyond primary level. Only around 80% of rural areas have sufficient primary and secondary educational resources. 30% of the population is illiterate (40% women; 16% men). 33% of men and women have attended primary school only [7].

The Angolan penal code is largely inherited from the Portuguese colonial legal system. The penal code used to prohibit "acts against nature" which included homosexuality, referred to as "an offence against public morals". However, there have been few reports of arrests or legal sanctions for homosexual activity in the country, suggesting that this code was rarely applied [8]. The provision criminalizing homosexual relationships was abolished in January 2019 and the amended penal code now specifically prohibits social and economic (e.g. employment) discrimination of individuals on the grounds of their sexual orientation. [9] There are no indications that the government will also be supportive to same-sex marriages (in 2012, at the time of the general elections, all political parties except one rejected the idea [8].

Abortion is illegal with a practical exception for saving the life of a pregnant woman and the penalty for performing an abortion can range from 2 to 8 years imprisonment. Efforts to reform abortion laws have been strongly opposed by the Catholic Church in Angola.

Structures of Gender Inequality

Angola is a country with rigid gender norms, supported by religious organisations and traditional cultures. Gender norms are reinforced through the education system [8]. There is evidence of strong family pressure for young people to marry a partner of the opposite sex [8].

Levels of gender inequality are high with Angola ranking 126th out of 145 countries in the World Economic Forum's Global Gender Gap Index. Sexual and gender-based violence is frequent. Almost one-third (32%) of women age 15-49 have experienced physical violence since age 15. In the past year, 22% experienced physical violence. Among ever-married women who have experienced physical violence since age 15, nearly three-quarters (73%) reported that their current husband/partner committed the violence. Eight percent of women age 15-49 have ever experienced sexual violence. Experience of sexual violence is greater in urban areas than in rural areas (9% vs. 6%) [6].

A recent study on health care professionals' perceptions about intimate partner violence suggested that there was still a strong influence of norms reinforcing the idea of male superiority and women's roles as mothers and wives which results in a tendency to blame victims of domestic violence [10].

Key issues per young key population group

There is very little published research on young key populations in Angola. This lack might demonstrate a lack of interest in the subject (given low HIV prevalence rates), and also perhaps a weakness of research infrastructures within the country.

Young sex workers

Sex work is common in Angola, but there is little research on SRHR of sex workers. An INLCS report (2018) estimates that there are 32,700 female sex workers in Luanda, 5,700 in Benguela, 6,000 in Bié, 8,200 in Cabinda and 1,400 in Cunene [11]. HIV prevalence amongst sex workers is estimated at 4.7% [12].

One study on young female sex workers aged 15-24 showed that 76% of respondents reported that they had their first sexual relationship when they were younger than 15 years old. Many had several concurrent sexual partners, and partners who were more than 10 years older than them [13]. The primary reason for these women engaging in sex work was reported to be financial difficulties and unemployment.

Young lesbian, gay, bisexual, transgender and intersex individuals (LGBTI)

UNAIDS (2016) estimates that there are 23,067 MSM in Angola and 51% of MSM living with HIV are on ART [12]. The principal references for this estimate is an integrated biological and behavioural survey (IBBS) survey conducted in 2013. There have been two other IBBS studies; one in 2011/12; the other in 2016/7 [14, 15]. The study reported by Kendall et al. (2014) estimated that there were 6236 MSM in Luanda Province [14]. Of a total of 203 participants in this survey, 61.8% reported that they had never tested for HIV, and there was low reported use of condoms. The research also found that 70.4% of the MSM surveyed had experienced homophobia, and 10% had been the victims of physical violence because of their sexual orientation. Forced sex was also frequently reported: "A quarter of participants reported having been forced to have sex against their will. For many, this occurred in childhood and adolescence. Friends and acquaintances were most cited" (op cit: 7).

The recent publication of some results from two provinces Luanda and Benguela based on the 2016/7 IBBS study confirm many of the previous findings, showing relatively low use of HIV testing services (in part, perhaps, because of lack of availability) [15]. 47% of MSM in Luanda, and 36% in Benguela, had '"ever tested for HIV and received test results". Risky sexual practice was common. 79% MSM in Luanda reported having recent penile-vaginal sex without using condoms; fewer (55%) reported the same for recent anal sex with a man. Likewise, 71% MSM in Benguela reported not using condoms in recent penile-vaginal sex and 67% reported the same with regard to recent anal sex with a man. HIV prevalence rates from the study as a whole were similar to those reported above: 1.9% for MSM and 8.8% for transgender women [11].

Young people who inject drugs

There is anecdotal information that use of injectable drugs is rare in Angola; rather, the country is a transit point for cocaine smuggling from South America to Europe. There was a press media report in 2016 which highlighted the practice of inhaling petrol amongst children who live on the streets of cities and that "The country's Association Against Drugs Abuse estimates that around 15 percent of juvenile drug users are abusing gasoline, before advancing to crack cocaine and other hard drugs" [16]. However, we have not found any information on the use of 'crack cocaine and other hard drugs'.

Young prisoners

Angola has a relatively small prison population but the majority, it seems, are adolescent and young adult males. In principle, only juveniles aged 16-18 years old may be detained in prisons as 16 years the age from which an individual is deemed legally to be capable of bearing responsibility for crimes (whilst 12 years is the age at which an individual can be charged for offences) and, supposed, juveniles younger than 16 years "are supervised in their homes" [17]. Nonetheless, other reports refer to the incarceration of individuals 12 years and older [18]. Notably, government officials acknowledge the presence of these 'minors' in prisons but have asserted they are housed in cells separate from those of adult prisoners [19]. The reports do not include information on the health and welfare status of adolescent and young adult prisoners. What can be inferred is that they experience very difficult conditions in view the limited capacity and capabilities of the prison services "to provide adequate medical care, sanitation, potable water, or food… it was customary for families to bring food to prisoners" [18]. However, there is no information on the SRH and HIV-related health risks for young prisoners.

Conclusion

There is very little information about certain young key populations in Angola, but a social determinants of health framework allows us to understand the complex interplay of structural, systemic and proximal determinants that may lead to risk and vulnerability for these young people. The importance of socio-economic determinants and specifically the high levels of economic inequality following the long civil war and the impacts of the oil price downturn from 2014, cannot be overlooked but must also be understood as mediated by highly entrenched structures of gender inequality which impact on family, peer and community networks. Improving SRHR for young people in key populations thus calls for interventions not only at individual level but through policies which tackle these wider systemic and proximate determinants of health.

1 Groups of young people considered 'key populations' in the HIV response include sex workers, lesbians, gays, bisexuals, transgender and intersex people, people who inject drugs and prisoners

2 HEARD collaborates in this project with the United Nations Development Programme (UNDP) and African Men for Sexual Health and Rights (AMSHeR).

References

[1] Tvedten, I. (2016). Marginalisation and poverty in rural Angola, CMI Brief

[2] CMI (2016). Violence against women in the context of urban poverty in Angola.

[3] ADEA (2014). *Angola Country Report for the 2014 Ministerial Conference on Youth Employment*

[4] Rodrigues, C. (2010). 'Youth in Angola: Keeping the pace towards modernity', *Cadernos de Estudos Africanos*, 18/19: 165-179.

[5] Froystad, M., Maestad, O. and Villamil, N. (2011). *Health services in Angola: Availability, quality and utilisation*. CHR, Michelsen Institute.

[6] INE (2016). 2015-16 *Multiple Indicator and Health Survey* (IIMS) INE (Angola National Institute of Statistics), MINSA (Ministry of Health) and MPDT (Ministry of Planning and Territorial Development). Luanda.

[7] INE et al. (2017). *Key Findings of the 2015-16 Angola Multiple Indicator and Health Survey* Instituto Nacional de Estatística (INE), Ministério da Saúde (MINSA), Ministério da Planeamento e do Desenvolvimento Territorial (MPDT) and ICF. Luanda.

[8] The Other Foundation (2017). *Canaries in the Coal Mines: An analysis of spaces for LGBTI activism in Angola*.

[9] Assembleia Nacional (2003). República P da. Decreto no 43/03, de 4 de Julho, *Regulamento sobre o HIV/SIDA, Emprego e Formação Profissional*. Luanda: Assembleia Nacional; 2003. p. 1–259.

[10] Nascimento, E. et al. (2014). 'Perceptions and practices of Angolan health care professionals concerning intimate partner violence against women', *Cadernos de Saude Publica*, 30 (6): 1229-1238.

[11] INLCS et al. (2018). *Relatório Final: Mapeamento Programático e Prevalência de VIH e outras ITS entre Populações Chave de Angola: Estudo PLACE 2017*. Instituto Nacional de Luta contra a Sida, Luanda, University of North Carolina, Chapel Hill, FHI360.

[12] UNAIDS (2016). HIV and AIDS Estimates Country factsheets Angola 2016 http://www.unaids.org/en/regionscountries/countries/angola

[13] Pinho, A. Sampaio, C. Monteiro, S., Murray, L. and Bastos, F. (2016). Sex, love and money along the Namibian-Angolan border. *Culture, Health & Sexuality*, DOI: 10.1080/13691058.2016.1150512

[14] Kendall, C. et al. (2014). 'Population size, HIV and behaviour amongst MSM in Luanda, Angola: Challenges and findings in the first ever HIV and syphilis biological and behavioural survey', *Journal of Acquired Immune Deficiency Syndrome*, 66(5): 544-551.

[15] Herce, M. E., Miller, W. M., Bula, A., Edwards, J. K., Sapalalo, P., Lancaster, K. E., ... & Weir, S. S. (2018). Achieving the first 90 for key populations in sub□Saharan Africa through venue□based outreach: challenges and opportunities for HIV prevention based on PLACE study findings from Malawi and Angola. *Journal of the International AIDS Society*, 21, e25132.

[16] Khumalo, S. (2016). *Petrol: a child's drug of choice in Angola*, 16th January. https://www.iol.co.za/news/africa/petrol-a-childs-drug-of-choice-in-angola-1012577

[17] Cole, B. and Chipaca, A. (2014). Juvenile delinquency in Angola. *Criminology & Criminal Justice*, 14,1: 61– 76.

[18] United States Govt. (2017). Angola 2017 Human Rights Report. https://www.state.gov/documents/organization/277211.pdf

[19] OHCHR. (2018). *Committee on the Rights of the Child considers reports of Angola*. United Nations, Office of the High Commissioner Human Rights.

Further information:

Further details on this multi-country research project can be found on https://www.heard.org.za/research-post/linking-policy-to-programming-2/ and on https://www.africa.undp.org/content/rba/en/home/about-us/projects/linking-policy-to-programming.html

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