ANGOLA 2017
CHILD WELL-BEING ANNUAL REPORT

Building a Brighter Future for Children in Angola

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<u>ACRONYMS</u>

A&D	Assessment and Design
ADM	Municipal Administration
ADP	Area Development Program
CMAM	Community Management of Acute Malnutrition
CS	Child Sponsorship
DME	Design, Monitoring and Evaluation
DMS	Municipal Health Directorate
DPS	Provincial Department of Health
DPP	Disaster Risk Reduction
DW	Development Workshop
EDA	Agronomic Development Station
EPI	Expanded Program on Immunization
ER	Expected Result
GAM	Global Acute Malnutrition
GoA	Government of Angola
HDI	Human Development Index
IIA	Institute of Agronomic Investigation
INGO	International Non-Governmental Organization
IPM	Integrated Programming Model
ITN	Insecticide Treated Nets
ITT	Indicator Tracking Table
IYCF	Infant and Young Child Feeding
LA	Local Authority
LEAP	Learning through Evaluation with Accountability & Planning
LLITN	Long-Lasting Insecticide Treated Nets
MAM	Moderate Acute Malnutrition
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MoA	Ministry of Agriculture
MoE	Ministry of Education
MoH	Ministry of Health
MSU	Michigan State University

MUAC	Middle Upper Arm Circumference
NSA	Non-State Actor
PAR	Participatory Action Research
PBAS	Partnership Budget and Actual System
PMIS	Program Management Information System
RC	Registered Children
SAM	Severe Acute Malnutrition
SO	Strategic Objective
SWOT	Strengths, Weaknesses, Opportunities, Threats
UNACA	Angolan Farmers Association
WVA	World Vision Angola
WV	World Vision
USG	United States Grant

EXECUTIVE SUMMARY

This is the third child well-being report for World Vision International - Angola (WVA) which highlights the annual achievements contributing to our strategy for 2017-2021. In FY17 WVA celebrated high impact achievements in terms of sustainable impact on the well-being of the most vulnerable children. The NO adjusted its 2016-2020 strategy to 2017-2021 to build on the successes from the previous years with a more focused approach for addressing challenges to the sustained well-being of Angolan children, especially the most vulnerable children within families and communities. WVA is contributing to the well-being of most vulnerable children through:

1) Ensuring that 250,000 children live in a safe environment and experience the love of God;
2) Extend and enrich education services to 250,000 vulnerable children; and,
3) Improve the Health and Nutrition status of 2,500,000 most vulnerable children.

More details on our NO strategy is provided in Annex 1. Progress has been made over the past years to improve the tracking of indicators to measure impact on the well-being of children. The office is also carrying out a national vulnerability mapping exercise which coincides with the Angolan government's prioritization of vulnerability mapping. This will inform WVA NO strategy alignment to address the issues affecting the most vulnerable children in rural Angola.

Although Angola is the 2nd largest oil producer in Africa, the majority of its population still live below the poverty line. Angola was reclassified from upper middle-income to a low-middle income country[1] with a Human Development Index (HDI) of 0.532 (UNDP 2015) positioning the country at 150/188 HDI.[2] Angola has high disparities in income distribution[3] between urban and rural areas. Angola has higher rates of child stunting (38%), wasting (5%) and underweight (19%)[4] compared to other countries in the region[5].

This report documents the overall WVA program contribution to child well-being within this context during FY17 and summarizes the impact of ten development and three emergency response projects funded by corporations, foundations, government donors and PNS/match funding. The WV Angola program in FY17 reduced vulnerability, built resilience and contributed to the well-being of 1,546,674 children (546,239 children directly and 1,000,435 children indirectly). The average cost per child for broad based interventions was US$ 7.09. The following impact indicators are structured by CWB targets and alignment with WVA's strategic objectives:

- ✓ A total of 8,240 children diagnosed with severe acute malnutrition (SAM) and 6,805 diagnosed with moderate acute malnutrition (MAM) were enrolled into an outpatient treatment program and supplementary feeding program respectively. From the total SAM number of children enrolled into the treatment program, 1,445 (17.5%) were first enrolled into the inpatient treatment program because they had medical complications or edema.
- ✓ To link communities to health facilities, WVA trained 327 Community Health Agents (CHAs). As a result, the CHAs screened 157,832 children and provided Infant and Young Child Feeding counselling to 26,810 mothers and caregivers of children under the age of 5 years.

[1] https://blogs.worldbank.org/opendata/new-country-classifications-income-level-2017-2018

[2] http://hdr.undp.org/sites/default/files/2016_human_development_report.pdf

[2.] GINI coefficient 2008 of 42.7 ranked 53 out of 153 countries

[4] Angola 2015-16 Multiple Indicator and Health Survey

[5] A Snapshot of Nutrition Situation in Africa - www.unicef.org

- ✓ An estimated 54,893 people of whom 33,122 were children have access to safe water through WVA´s rehabilitation of 114 water points (102 in communities, one at a health facility and 11 at schools).
- ✓ An estimated 63,594 people of whom 30,187 are children benefited from improved sanitation facilities through WVA´s contribution to 6,330 latrines.
- ✓ An estimated 4,793 caregivers were sensitized on appropriate hygiene practices.
- ✓ 72 communities were declared Open Defecation Free (ODF) benefiting 63,594 people.
- ✓ An estimated 21,435 children under 5 were treated at the community level for malaria with WVA support through government Community Health Agents (ADECOS).
- ✓ An estimated 128,740 people were treated at government health facilities for water bone related diseases with the support of WVA.
- ✓ An estimated 21,000 people received protection from malaria and other infectious diseases through the use of 3,000 ILLTNs distributed by WV at health facilities, pediatric and maternal wards.
- ✓ The productivity of an estimated 3,000 households increased as a result of reduced travel distance of caregivers seeking malaria treatment with treatment at the community level.
- ✓ Deworming of 315,353 children.
- ✓ Over 1,208 caregivers, faith and community leaders participated in workshops organized by WVA to promote faith and development and the spiritual nurturing of the children in their communities.
- ✓ An estimated 172 mothers were helped to obtain birth certificates for their children and thereby providing access to primary education enrollment.
- ✓ 23 collective land titles and 517 cadaster titles issued by government with WVA support benefited 12,818 people.

Table 1 shows a summary WV Angola resource contribution to child well-being in FY17.

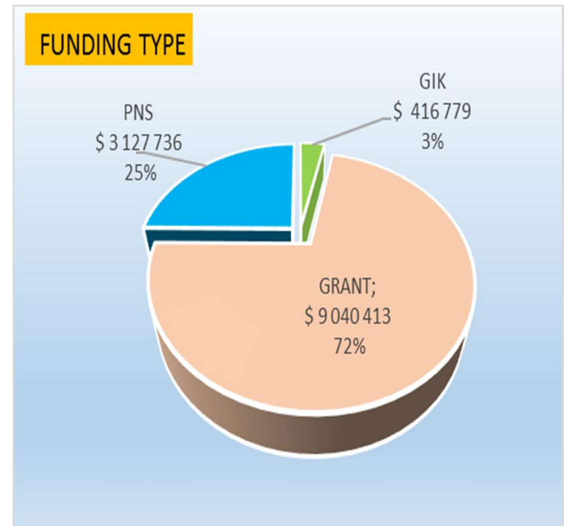
Table 1: WVA Projects Contributing to the Well-being of Children in FY17

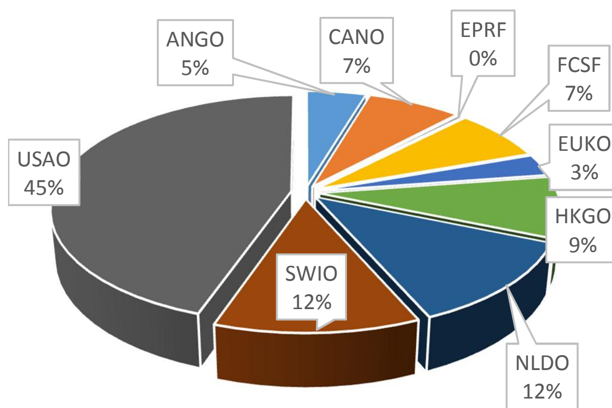
Project Name	**Donor**
Ensure children live in a safe environment and experience the love of God	
Children Commitment	WVUS & WV Angola fragile context funding match funds
Improve Health and Nutrition status of vulnerable children	
Global Fund	Global Fund
Emergency	
USAID OFDA Securing Angola´s Future	USAID
ECHO	ECHO
Yellow Fever and Malaria Response	ExxonMobil
WVHK Securing Angola´s Future	WVHKG
Refugee Emergency	UNCHR, UNICEF & WFP
Gifts-in-Kind	WV Canada & WFP
Project Enablers	
WASH	
WASH HKG	WVHKG
WASH PB	WVUS
WASH El Niño	WVHK
Livelihood	
EC Land Tenure	European Union
TOTAL Women Entrepreneurs	TOTAL
Securing Angola´s Future (AIF)	Government of Angola
Total Expenditure	

Finance and GAM

The major achievements were:

- Approved cash funding of US$ 11,566M or FY17 and US$ 10,604M for FY18;
- 11.9% savings on support cost budget of $1.9M;
- 88.8% burn rate on project spending;
- Improved Admin Cost Ratio of 17% by 3rd Quarter of FY17 vs 30% in FY16;
- Overspending reduced FY16 to FY17 by 44%;
- Enrollment in internet banking;
- Consistent improvement in cash liquidity;
- Improvement on Bank Reconciliation Reports as compared in FY16;
- FY 2018 Approved Budget at $9M including emergency response; with approved FCSF funding of $1M;
- GEMS implementation.

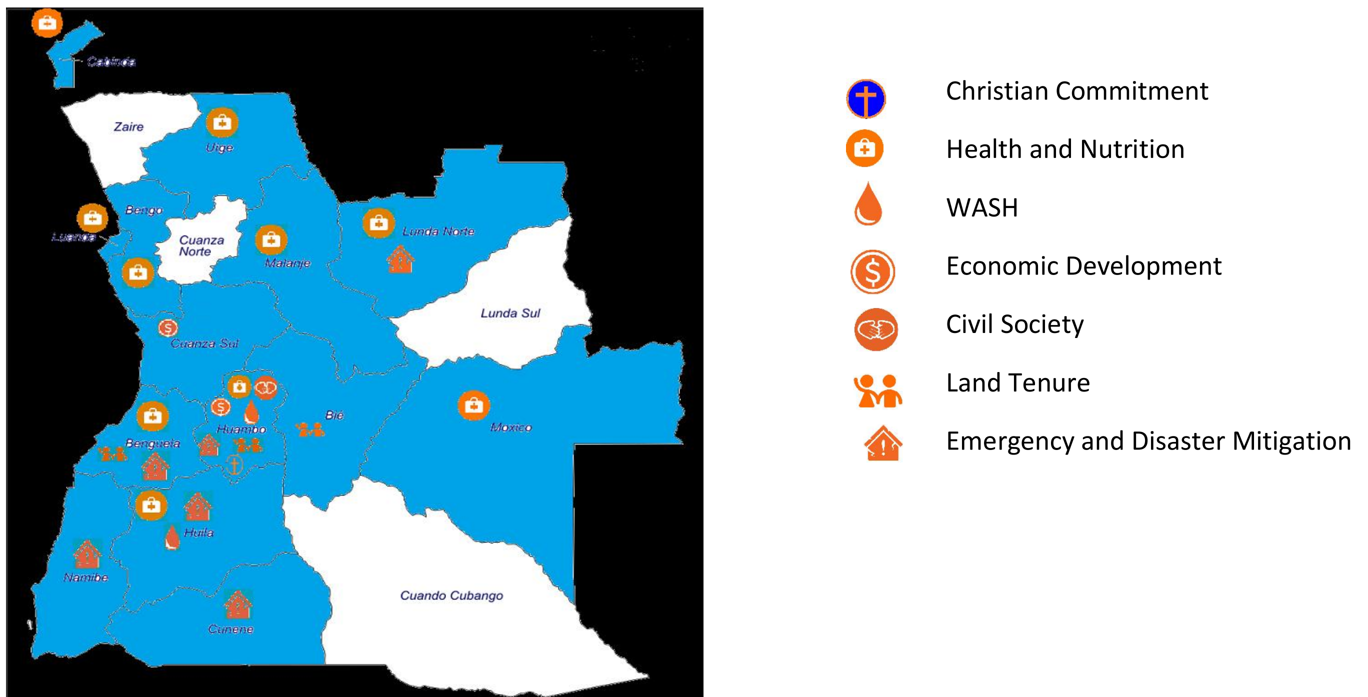




1. Introduction

The purpose of this report is to highlight the overall contribution to the sustained well-being of children, especially the most vulnerable within their caregivers and communities through 13 projects in communities of 14 provinces achieved by WVA programs during FY17 as shown below. The report also highlights progress made towards the strategic objectives articulated in the NO strategy covering the period 2016-2020 now adjusted to 2017-2021 attached in Annex 1. The new strategy builds upon the previous one while providing greater focus on youth and child protection, health and nutrition and education in light of the context, opportunities and evidence. The report also aims to present ongoing plans to align the office to the WVI OurPromise2030 and subsequent effective use of data to spur development efforts and implement successful interventions. In addition to internal use, it is intended that this report will form a basis for an Annual WVA Report for external consumption that can be distributed to both existing and potential donors. It is also an opportunity for staff to reflect on the contribution to CWB and improve the efficacy and efficiency of interventions.

Figure 1: World Vision Angola Intervention Area Map



In the period under review, WVA contributed towards the global targets on child well-being by focusing its programming in child protection, and health and nutrition areas. The following key outcome indicators are included in the report.

In Angola only about 37% of children are registered at birth. The majority do not possess birth registration as their parents do not possess them too. Without registration of the majority of children, government planning for interventions on child well-being are underestimated or directed to areas with less children in need thereby making them forfeit protection and enjoyment of rights that the Angolan state is obliged

to provide which are included in the 11 government commitment[6] to children. It is worth noting that the Angolan government has Policies and Conventions on child protection but the same finds it difficult to plan and monitor these policies and conversions as children are not registered and their location unknown. During the period under review, WVA worked with government institutions at national, provincial and community levels as well as with local and international partners to address some of the issues affecting children in the communities we work. The effects of WVA´s efforts are yielding positive results although a lot more needs to be done in partnership. For the reporting period, 172 mothers were facilitated to obtain their birth registrations which consequently led to 102 of their children get their birth registrations too and get enrolled to primary education.

Angola has high levels of under-five stunting (38%), underweight (19%), wasting (5%), and only 31.1% of children are exclusively breastfeed. Only 50.7% of Angolans have access to improved water and sanitation facilities and households have to travel for not less than 20 Kms before they can reach a health unity to which on arrival only 75% are considered operational with only 10% of them reporting access to potable water. Against this backdrop of uneven development, families are struggling to raise their children in a safe and healthy environment, and the government is rising to a massive challenge of providing essential services for all. To reduce the distance caregivers have to travel to health unities, WV supported ADECOS (Community Health Agents) to screen 21,435 under-five children for malaria, from which 14,935 resulted in malaria positive cases and were treated at community level thus making time more available for caregivers to be involved in income generation activities.

Strategic focus, progress towards outcomes and learning

Timely reliable and robust data is critical for developing appropriate policies and interventions for the achievement of sustainable well-being of children. The child well-being report has fostered the strengthening of statistical systems to enable the production of quality data for monitoring progress towards child well-being targets. Lessons continue to raise from the iterative process of producing the report which has influenced the adjustment of the strategic focus of the NO for the next 5 years.

The CWBR of FY16 informed and influenced several key processes and products in FY17. Notably, the strategic plan of 2017-2021 drew from the recommendations and feedback of the CWBR, including key strategic objectives level recommendations as well as reflections on the M&E system capacity for generating sound evidence and learning. The 2017-2021 strategy emphasizes upon strengthening evidence-based programming, involving partners at all levels increasing influence and integrating programs for greater child well-being impact, improving the focus on most vulnerable children, youth and their caregivers and encouraging our voice and influence through greater advocacy. Progress towards strengthening evidence based programming included increased efforts and investment on tracking and reporting project progress and evaluation results including standardized outputs and annual outcome monitoring using non-LQAS.

Based on the outcomes of the national vulnerability mapping of children in Angola to be concluded by February 2018, Technical Approaches (TAs) on our priority strategic areas (Child Protection, Health and Nutrition and Education) enabled by WASH and Livelihood will be elaborated for FY17-21. Table 2 summarizes the strategy objectives, key results and child well-being outcome evidence gathered during the FY which has been applied to demonstrate progress toward the FY17-21 strategy targets.

About the Data

Being a grant funded office, WVA monitored and collected most of the data on donor oriented indicators. The QA team led by the Program Associate QA Director supported by the Senior Management Team

[6] Resolusão_5-08_18.01.2008_11_Compromissos_da_Criança

(SMT) composed of managers working on CP, Health and Nutrition, WASH and Livelihood aggregated the data needed to put the report together. The report was drafted using the SARO guideline to the compilation of CWBR. The initial step was the formation of the CWBR team led by the M&E Specialist, staff from all projects contributing to child well-being in Angola which scanned all available data, populating and validating the data matrix, finding additional data and the compilation of the report. The team had a review meeting where lessons from the previous report writing process were drawn and recommendations and actions crafted for the FY17 report. Since Angola is a small program office, the team working on the CWBR was also small composed of the M&E Specialist and four project managers each of these contributing to the areas their projects contributed to. The team decided on which project data was relevant to the CWBR and made recommendations on future projects´ programming to include WVI standard indicators although grant funded. To achieve this, a series of Joint meetings followed by conference calls were contacted and reviews of every area were done to align the national office programs to the global strategy. Core team members linked with others in their departments to verify information, contribute to interpretation and fill gaps. The Associate Resource Acquisition and Quality Assurance Director was part of the core team and shared key milestone products with the senior leadership team for validation and feedback. Key results will also be shared with stakeholders to collect their opinions and recommendations including the integrated operations review, PST face to face and in the development and review of technical approaches and program in FY17-21.

Despite notable progress registered regarding data collection, analysis and interpretation, the national office team also acknowledges challenges and limitations.

- Despite attempts to disaggregate data by sex, age group, location, not all data variable could be analyzed by these indicators. Where available, the data that was collected has been disaggregated so as to track progress accurately in communities across marginalized and disadvantaged groups to map out inequalities.
- Data obtained from different projects responding to the same strategic that had conducted evaluations could not be easily compared because of significant differences in their program designs and donor requirements. Not all projects have the same focus as donors are different and therefore different indicators were measured. The majority of donor indicators do not converge with WVI standard indicators on the child well-being. However data obtained from common indicators has been used.
- In cases where data presented responds to a specific WVI standard indicator but presented to respond to donor requirement, estimates on the number of children and HHs benefited was estimated using national data on statistics or surveys carried out by other institutions which may be misleading.
- Unavailability of thresholds for most of the projects to compare indicators. Indicators for Strategic Objective1 and 2 have limited local and international thresholds that can be used to ascertain progress. Strategy targets were instead used to provide perspective.
- Despite efforts being made by a small team in the Quality Assurance department, most of donors still do not accept a 100% budget on the M&E staff for their funded projects. The funding of a small percentage of the M&E function constrains a full follow-up and adjustment of project programming as the project managers at times required to do the M&E duties have limited knowledge and time for the same.

2. Reporting Process

FY17 was a year of significant organizational change for WVA. The motivation for these changes was to enhance the quality of WVA´s programming, the efficiency and effectiveness of its internal processes and to prepare WVA for future challenges in the operational and organizational contexts given its country and funding context. The office was changed from a national to a program office given its size. In order to identify the optimal trajectory change, WVA leadership designed a thorough, participatory process to map existing business processes and to develop improvements to them. This mapping process led to the adoption of a different organizational structure and the redesign of a large number of jobs particularly on the SLT and SMT positions as shown in Annex 2. The process was designed to minimize costs while achieving more vulnerable children. The new staffing structure will come into effect from 1st October 2017.

As a recommendation from FY16, the office started to involve staff regularly on the strategy conversations to ensure everyone is up-to-date with the organizations´ direction to achieve OurPromise2030. The above improvements were possible deal (directly or indirectly) to learnings the office had in coming up with the FY16 CWB Report. Whilst the time invested in the restructure has not yet allowed for attention to all of the last year's challenges, several other important lessons have been actioned and are summarized below:

1. Project models. Project models that will be used greatly or improved on to contribute to the child well-being of our selected technical approaches have been selected. The office will be able to complete the development of the three Technical Approaches that the office will be reporting to.
2. Improvements in monitoring. There were several recommendations on enhancing monitoring systems and the adoption of standardized indicators to grants. During FY17, baselines and evaluations, included WV standard indicators as far as possible in line with donor requirements. Many of the results of the surveys and evaluations are highlighted in this report.

Noting that our FY16 indicators were more donor specific than aligned with WVI standard indicators, the office has gradually started working with donors and all stakeholders to ensure WVI standard indicators are included in all projects which can be seen in this report although not to the required level. Our revised its strategy when approved will be shared with our main donors to ensure their funding best contributes to the child well-being through WVI standardized indicators and thereafter fully align WVA to the global strategy. Based on WVI indicators, all project managers teams were requested to negotiate with their donors and thereafter to populate the indicators which submitted to the M&E Specialist for quality checks, where doubts were found, the project teams were requested to clarify. In last years´ report, the rate of a double count of beneficiaries was a bit higher as beneficiaries benefiting from different WVA projects were counted for each of the projects and summed up. This year, this was reduced as projects in the same areas consolidated their beneficiary figures.

3. Strategic Objectives

CHILD PROTECTION

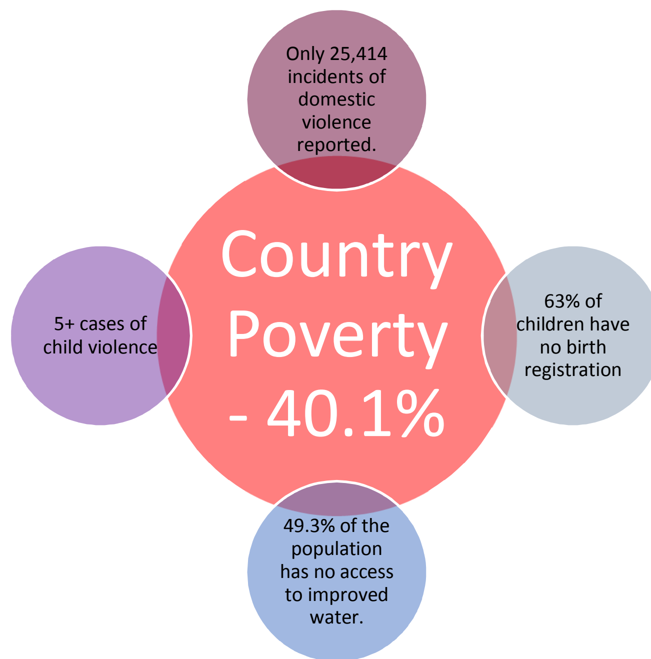
3.1 Strategic Objective 1: Ensure 250,000 children live in a safe environment and experience the love of God.

Strategic Objective	Ensure 250,000 children live in a safe environment and experience the love of God.	CWB OUTCOME	INDICATORS
		Children are cared for, protected and participating	• Proportion of adolescents who know of the presence of services and mechanisms to receive and respond to reports of abuse, neglect, exploitation or violence against children • Proportion of adolescents who report that their views are sought and incorporated into the decision-making of local government • Proportion of known child protection cases followed up by community child protection committee • # of CAY who meaningfully participate in actions that support ending violence against children • # of parents trained in courses/workshops that tackle positive discipline (i.e. Celebrating Families, and other CP issues) • Proportion of community members participating in attitude/behavior change sessions on child protection issues • Proportion of child protection services/facilities improved based on performance measures defined by community
Tartget	Children report an increased level of well being		

3.1.1 Country Context

In June 2017, Angola was reclassified as a Lower Income country from an upper middle income country and the 2nd largest oil producer in sub-Saharan Africa after Nigeria.[7] Although a second largest oil producing country and some tentative progress made, the situation of the Angolan children is serious and worrying due to poverty and associated problems like malnutrition, lack of water, health, abusive and exploitative relationships, early marriage, child labor and traffic, children in emergency, conflict and crisis situations, juridical situations where children as victims, criminals or witnesses, lack of schools, abandoned children, just to mention a few which all require the efforts from all sectors to alleviate these serious violations of the rights of children. The national vulnerability mapping will inform on the levels of exploitation, violence, abuse and access to justice, social protection services and practices and beliefs most prevalent in the country which are prejudicious to children.

[7] https://blogs.worldbank.org/opendata/new-country-classifications-income-level-2017-2018



- Only 37% of children are registered at birth, however this ranges from 15-69% depending on where children are born.[8]
- Due to lack of advocacy on human rights and child protection across the nation, knowledge by children and caregivers on their rights and where to report violence, only a few cases were reported for example in three provinces 68 cases on child labor and only 25,414 incidents of domestic violence were reported in 2015 and not desegregated and no data is yet available for 2017.
- Angola has the highest child death among the under-five with 157 deaths per 1,000 live births, comparable to other countries between 130 and 139 deaths per 1,000 children born.[9]
- Angola has the 3rd highest rate of child mothers with 170 births per 1000 women aged 15-19[10] with 4 out of 10 children between the ages of 12 to 17 entering into early legal or common-law marriages[11].
- 49.3% of Angolans do not have access to improved water & sanitation facilities.[12]
- 27% of young people are illiterate. In rural areas this increases to 60%.[13]

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[8] https://www.unicef.org/infobycountry/files/UNICEF_Angola_COAR_2015_ENG.pdf

[9] https://www.theguardian.com/society/2015/dec/30/born-lucky-world-bank-reveals-life-expectancy-rates-for-todays-infants

[10] https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_Reproductive_Paper_20160120_online.pdf

[11] Angola 2016 Human Rights Report https://www.state.gov/documents/organization/265434.pdf

[12] https://www.wsp.org/sites/wsp.org/files/publications/CSO-angola.pdf

[13] http://www.unesco.org/education/GMR2006/full/chapt7_eng.pdf

- 2% of rural girls attend secondary school, rising to 28% of girls living in urban areas.[14]
- 37% of children are registered at birth, however this ranges from 15-69% depending on where children are born.[15]
- In Africa, the average distance to a health post is 8km. In Angola, it's more than 20 km. On arrival, only 75% of health units are considered functional with 10% reporting access to potable water.[16]

3.1.2 Current Status

There were four projects that contributed to this strategic objective:

Project A) – Civil Society:

Geographical Area: Huambo

Project B) – Christian Commitment:

Geographical Area: Huambo

Project C) – Child Protection Program Lunda Norte Refugee Emergency:

Geographical Area: Lunda Norte

Project (D) – Women Entrepreneurs, Porto Amboio:

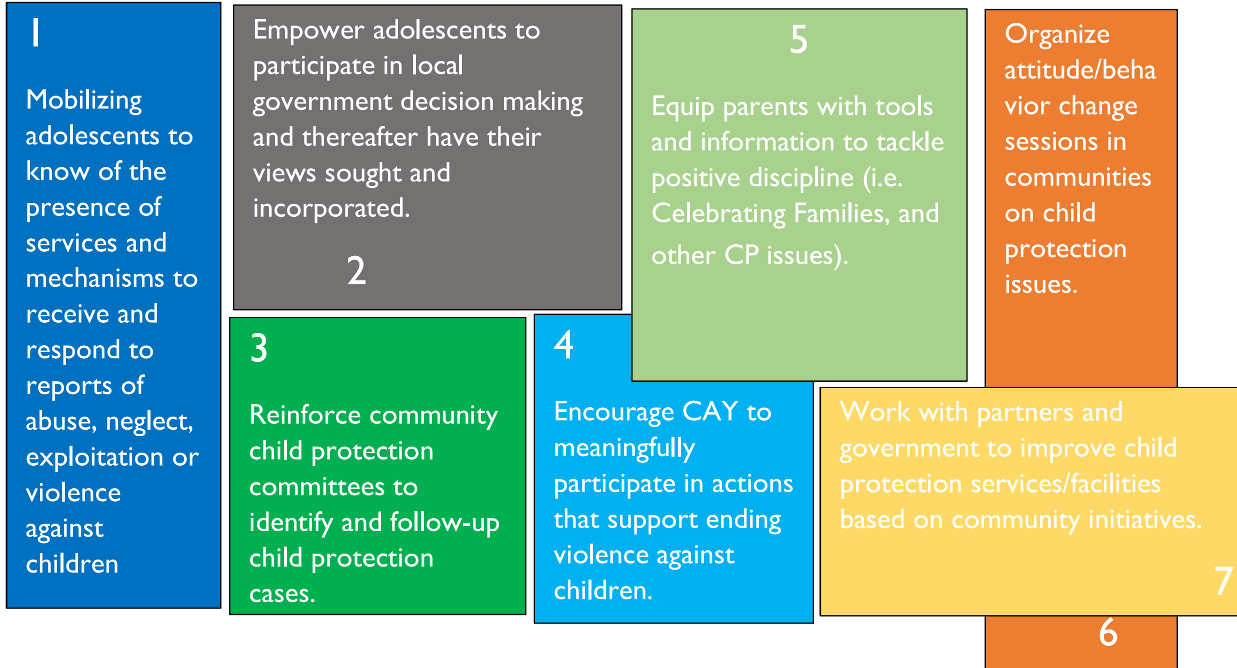
Geographical Area: Kwanza Sul

[14] http://en.unesco.org/gem-report/sites/gem-report/files/regional_overview_SSA_en.pdf

[15] https://www.unicef.org/infobycountry/files/UNICEF_Angola_COAR_2015_ENG.pdf

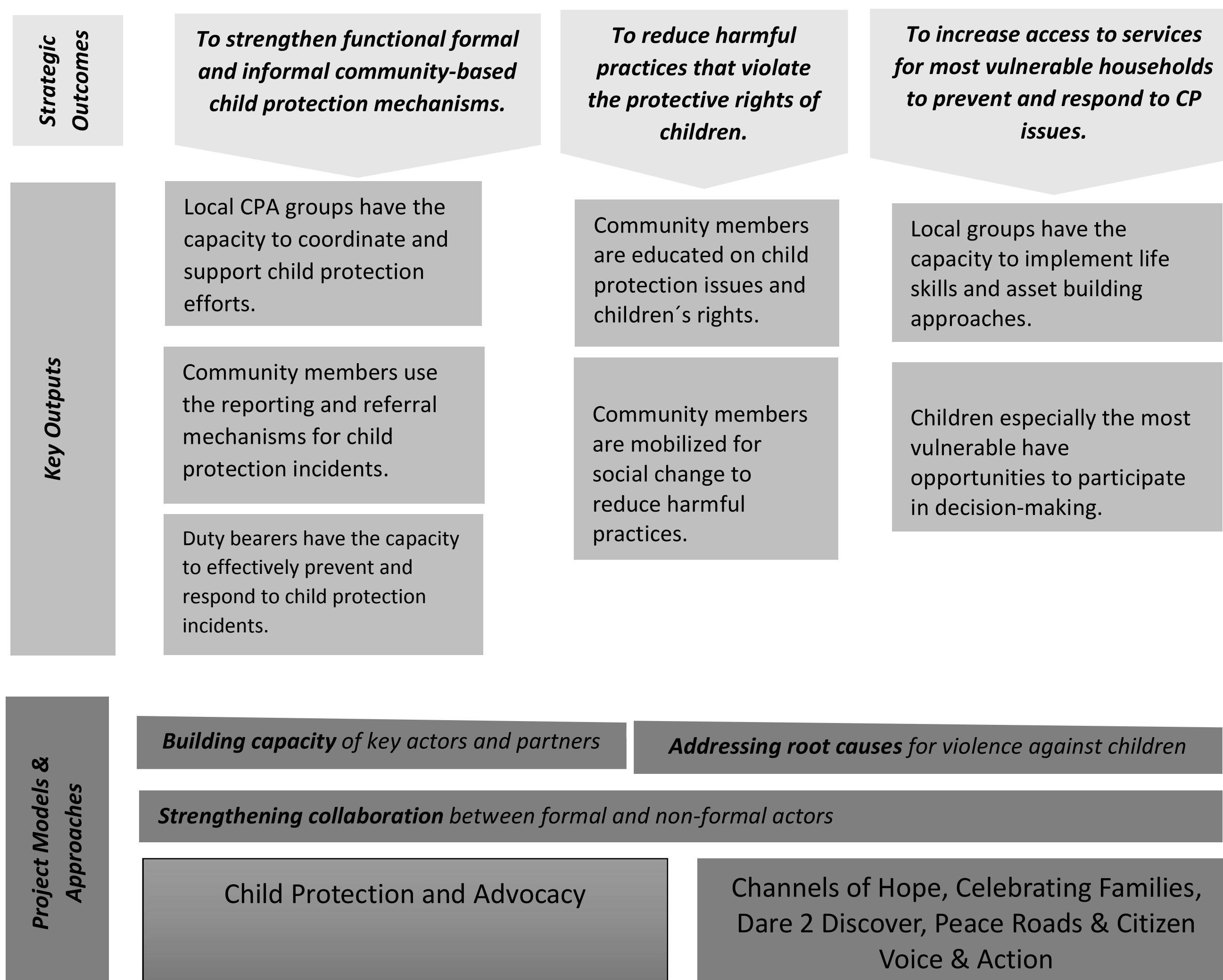
[16] http://www.who.int/hac/crises/ago/background/Angola_Dec05.pdf
https://www.cmi.no/publications/file/4319-health-services-in-angola.pdf
https://books.google.co.ao/books?id=JLETx00_YlcC&pg=PA117&lpg=PA117&dq=Average+distance+to+health+facilities+in+Angola&source=bl&ots=t4A1zbn66S&sig=T01ybCpsW0eSwSWm0ReWDwPu4O8&hl=pt-PT&sa=X&redir_esc=y#v=onepage&q=Average%20distance%20to%20health%20facilities%20in%20Angola&f=false

7 MAJOR CHILD PROTECTION INTERVENTION RESULTS



- 34% of adolescents in the intervention area know of the presence of services and mechanisms to receive and respond to reports of abuse, neglect, exploitation or violence against children.
- 10% of adolescents in WVA intervention areas report that their views are sought and incorporated into the decision-making of local government.
- Only 34% of known child protection cases were followed up by community child protection committees.
- Only 84 CAY who were reported to meaningfully participate in actions that support ending violence against children
- 1,208 parents were trained in courses/workshops that tackle positive discipline
- 840 out 1,214 community members participated in attitude/behavior change sessions on child protection issues
- 27 out of 41 child protection services/facilities were improved based on performance measures defined by community.
- None of the 27 CP&A groups had a shared plan

3.1.3 Child Protection Project Approaches & Key Outputs



3.1.4 Achieved RMNCH outputs in FY17

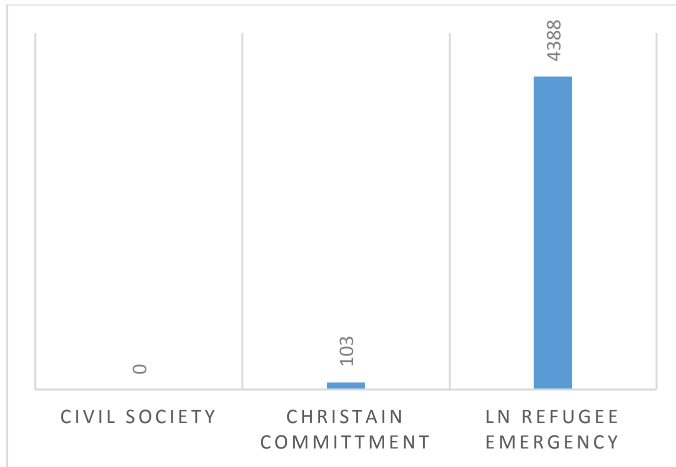
Output Indicator	***FY17 Achievement***	***Number of Projects***
Proportion of adolescents who know of the presence of services and mechanisms to receive and respond to reports of abuse, neglect, exploitation or violence against children	4,491 (26.52%)	3 – (A, B & C)
Proportion of adolescents who report that their views are sought and incorporated into the decision-making of local government	10 (10%)	1 – (A)
Proportion of known child protection cases followed up by community child protection committee.	156 (33.91%)	2 – (B & D)

# of CAY who meaningfully participate in actions that support ending violence against children	84	1 – (A)
# of parents trained in courses/workshops that tackle positive discipline (i.e. Celebrating Families, and other CP issues)	1,208	3 – (A, B & D)
Proportion of community members participating in attitude/behaviour change sessions on child protection issues	840 (61.14%)	3 – (A, B & D)
Proportion of child protection services/facilities improved based on performance measures defined by community	27 (65.85%)	1 – (A)
# of children participating in SNC activities	87,300	1 – (B)
Number and percent of catalysed faith leaders who report they are somewhat or highly motivated to act on Channels of Hope focus issue	50 (78.13%)	1 – (B)
# of parents that demonstrated increased knowledge on Celebrating Families and the SNC framework.	80	1 – (B)
# Church leaders, faith leaders, local family focused organizations and community leaders demonstrate increased knowledge on Celebrating Families and the SNC framework	161	1 – (B)

3.1.5 Progress Description

Being the first year for our NO to report on these indicators, comparisons in our program implementation areas has not been done. However, we tried to carry out a country comparison which was also not possible as many cases are not reported and government is also skeptical to release data which puts the country on a negative view to the public. Being affected by almost three decades of civil war, the majority of the population is illiterate and illiteracy brings with it ignorance of dissevered rights and obligations and hence fail to report most of the issues affecting children because either they are considered as ethnically acceptable, do not know where to report, afraid to report the perpetrator or do not know if it is an issue or not. With advocacy the projects carried out, populations in our implementation areas are starting to be aware of the cases, how to prevent them, where to report if they happened and how to help the victims. The Christian Commitment project started working with all WVA projects to ensure CP is incorporated in all and with advocacy by all.

Institutions to report to abuse, neglect, exploitation or violence against children exist in the country with legal laws and policies elaborated nationally and adapted from international conventions. However, advocacy of the same to adolescents has been minimal which led to only 26.52% adolescents reporting that they knew of the presence of services and mechanisms to receive and respond to reports of abuse, neglect, exploitation or violence against children. We cannot precisely say this percentage is low as the country has no threshold and data on the same is not available. Three projects reported on this indicator with the refugee emergency contributing most.



Proportion of adolescents who know of services and mechanisms to receive and respond to CP issues by projects.

Angola has child protection networks "redes tematicas de protection á criança" in every municipality. With the Civil Society project, WVA noting that initiatives exist in communities and local governments, supported these networks to sensitize its members on their rights of participation into public affairs and have their views heard and incorporated into government decisions. The 10% of adolescents reported clearly show that there is low advocacy and need to improve.

Institutions and policies to follow-up child protection cases exist in the country however, due to corruption by the perpetrators and most of the people in change to discourage such behaviors, most cases have not been given appropriate treatment and hence discouraging others to report and those who could make follow-ups. WVA through two of its projects in FY17 encouraged existing institutions and groups to continue with the follow-ups of any known cases. WVA assumes that its contribution at local level made a difference during the reporting period with the follow-up of 156 cases through its partners.

WVA seeks to contribute to an environment that promotes children, adolescents and youths´ participation in their care and protection, including their spiritual nurturing. WVA worked with its partners, ADESPOV, JOCU and the local communities which encourage 84 CAY to meaningfully participate in actions that support ending violence against children.

The 11 commitments to children prohibit negative discipline on children, however cases of negative discipline have been reported in the country. To encourage positive discipline, WVA supported trainings of 1,208 church leaders, youth leaders, partners, community members and parents.

Sustainability

PARTNERING

Collaborative partnerships established with churches mother boards, churches, government institutions at provincial, municipal and communal levels to ensure that the needs of most vulnerable children are met.

Partners include; INAC, ADESPOV, JOCU, APEC, CEF, Orphanages, CICA, AEA, ICRA, local governments, traditional authorities, municipal child protections groups.

Current economic crisis and lack of government support for civil society organizations likely to affect progress & sustainance of interventions by present partners.

TRANSFORMED RELATIONSHIPS	Build on community initiatives on child protection and advocacy.
HOUSEHOLD & FAMILY RESILIENCE	Capacity building of partners especially church leaders, local NGOs and government institutions to enhance project sustainability.

Key Learning	Recommendations
One of the major current challenges of churches within the WV areas of intervention is the lack of materials and poor quality of spiritual nurture for young children and youth in the Sunday Schools classes. Efforts have been mostly focused on reviewing the limited material they have and how it can be adapted to WV material.	In the absence of general material that can be accepted by all churches, priority was given translating WV material and training of faith and traditional leaders using WV material to provide appropriate spiritual nurture for children and youth.
It is essential that WV works with local partners to ensure a multiplication factor and guarantee the long term sustainability of project.	WVA to strengthen its partnership with APEC (Association for the Evangelism of Children in Angola) and CICA (Counsel for Christian Churches in Angola) in the implementation of this project.
The bringing together of different denominations for a common goal is widening the minds of main faith and traditional and hence leaving their own ways and adapting what is acceptance by the majority.	All WVA projects should adapt such partnerships which is creating a common understanding of child protection by different communities.
Children and young people are often more receptive to new ideas and the development of a society based on Christian principles	It should be clear to all of our partners that WVA CC program will focus on children and young people as the end beneficiaries and change agents in Churches and rural communities.
Most of children whether with reading difficulties or not learnt effectively with visual aids material.	The project should places emphasis on the training of trainers and the provision of quality visual Christian literature.

3.2 Strategic Objective 2: Extend & enrich education services

Nothing to Report (no project was funded under this SO).

3.3 Health and Nutrition

Strategic Objective	Improve Health and Nutrition status of 2,500,000 vulnerable children.	OUTCOME • Mothers and children are well nourished	INDICATORS • Proportion of households where all children under 5 slept under a long-lasting insecticide treated net (LLIN) the previous night • # and % of pregnant mothers and mothers/ caregivers with children 0-23 months who received nutrition & infectious disease counselling
Tartget	Increased in children protected		

	from disease and infection (ages 0-5) Increase in children who are well nourished	• Children and caregivers have increased access to primary healthcare • Increased access to safe water & sanitation • Increase in knowledge of sustained hygiene practices among children & communities	• # and % of COMM groups responding to root health issues • Number and percent of active ttC CHW AND # and % of trained and functional Community Health Workers/ Home Visitors (providing health services at the household level) by gender • revalence of stunting in children under five years of age • Prevalence of underweight in children under five years of age • Prevalence of wasting in children under five years of age • # and % of children 0-5 months of age exclusively breast fed in the last 24 hours by gender • # and % of children aged 6 - 59 months with SAM and/or MAM participating in CMAM programs (SC, OTP, SFP) who have been rehabilitated •

3.3.1 Country Context

Despite being the second lagerst oil producing nation, Angola continues to experience the highest maternal and child mortality from easily preentable and treatable diseases which include malaria, HIV, TB, diarrhoea, penomenia, acute respiratory infections, malnutrition, antinatal and postnatal complications. Malaria continues to be the second of underlying causes of maternal and child deaths affecting the majority of the populations especially children and pregnant women let it be in rural areas or urban. Since the minimum distance to a health in rural areas is 20 Km, most of the malaria cases and deaths are not registered as most of the vulnerable people adhire to traditional healing methods in the absence of health services. Those that go to seek medical attentions at most cases reach late and hence resulting in early deaths. A survey by INE indicates that only 31% of the Angolan population posses an ITN and only 20% and 21% of children under five and pregnant sleeping under an ITN and hence indangering the lives of the majority of them.

Many children continue to suffer from one or more forms of under nutrition that include low birth weight, anemia, underweight, wasting and stunting. On average, 38% are stunted, 5% are wasted, 19% are underweight and 65% are anemic in the country. Despite the funds constraints, WVA has susscefuly managed to contribute to government efforts on nutrion in the provinces of Benguela, Cunene, Huila and Huambo through its emergency and livelihood projects.

3.3.2 Current Status

Five projects contributed to this strategic objective:

Project A) – Global Fund - Malaria: On the components of Integrated Case Management (iCCM) and Health Systems Strengthening (HSS).

Geographical Area:

HSS – Benguela, Bengo, Cabinda, Huila, Luanda, Lunda Norte, Malange, Moxico and Uige provinces

iCCM – Bengo, Lunda Norte, Malange, Moxico and Uige provinces

Project B) – Yellow Fever and Malaria Emergency Response:

Geographical Area: Huambo and Luanda Provinces.

Project C) – Securing Angola´s Future (AIF): Improve Child Nutrition

Geographical Area: Huambo and Benguela Province

Project D) - ECHO: Promote appropriate infant and young child feeding (IYCF) and behavior change to prevent malnutrition and mitigate the influence of natural disasters.

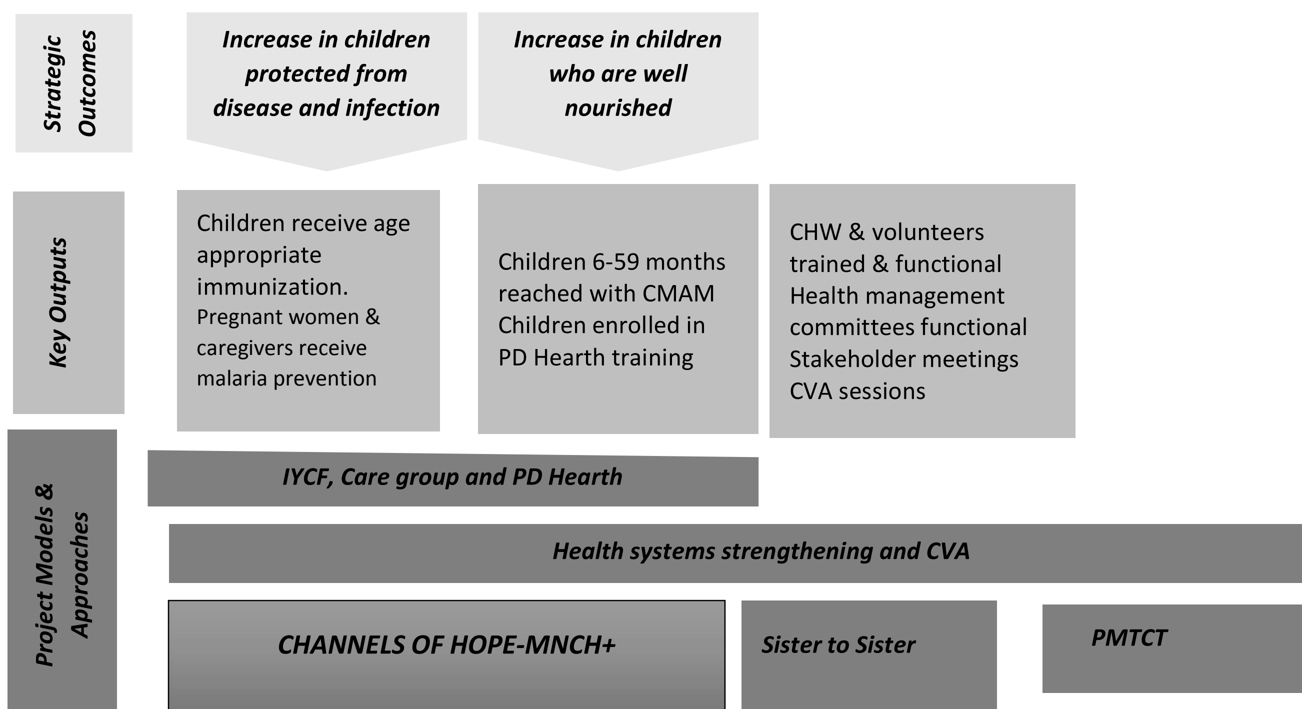
Geographical Area: Benguela, Cunene, Huila, Namibe and SW Huambo

Project E) – Integrated Emergency nutrition and WASH Response: Promote appropriate infant and young child feeding (IYCF) and behavior change to prevent malnutrition and mitigate the influence of natural disasters.

Geographical Area: Huila Province

- 3,000 LLINs distributed to caregivers of children under 5 and pregnant women at health unities
- Only 13.45% of the sampled households had their children under 5 sleeping under a long-lasting insecticide treated net (LLIN) the previous night
- 10,137 (37.26 %) of pregnant mothers and mothers/ caregivers with children 0-23 months received nutrition & infectious disease counselling
- 6 (100%) of COMM groups responding to root health issues
- 716 (42.14% of whom 22% are female and 78% male) active ttC CHW AND 100% of the active were trained and are functional Community Health Workers/ Community Health Volunteers/Home Visitors/Peer Educators (providing health services at the household level)
- 42.43% children under five years of age are stunted
- 22.13% children under five years of age are underweight
- 2.27% of children under five years of age are wasted, in one project improving to 0.78% wasting after a year of project implementation
- 450 (37.53%) of children 0-5 months of age exclusively breast fed in the last 24 hours by gender
- 9 pregnant women received micronutrient supplements
- 6,472 (60.39%) of children aged 6 - 59 months with SAM and/or MAM participating in CMAM programs (SC, OTP, SFP) were rehabilitated
- 275 of MINSA technicians capacitated on effective handling of Malaria cases and other preventable disease.
- Supply of medical supplies to health unities for malaria and respiratory diseases treatment.
- 94,916 people tested for malaria of whom 24,168 were children being 21,435 children under 5
- Treating of 14,935 malaria positive cases treated at eight government health facilities and the majority at community level by ADECOS (government community health agents) from a government institution Social Assistance Fund (FAS) trained by WVA and paid by the government
- 41,708 – People participating in nutrition education (benefiting indirectly 83,416 children)
- 38,285 – People participating in community kitchen activities (benefiting indirectly 76,570 children)

3.3.3 Health and Nutrition Project Approaches & Key Outputs



3.3.4 Achieved RMNCH outputs in FY17

Output Indicator	***FY16 Achievement***	***Number of Projects***
# of pregnant women and mothers/caregivers who received nutrition education (Infant & Young Child Feeding Practices) through community based health volunteers supported by WV	16,046	2 – (C&D)
Proportion of households where all children under 5 slept under a long-lasting insecticide treated net (LLIN) the previous night	13.49%	1 – (B)
# and % of pregnant mothers and mothers/ caregivers with children 0-23 months who received nutrition & infectious disease counselling	10,137 (37.26%)	1 – (A)
# of LLINs distributed - mass campaign and continuous distribution	3,000	1 –(B)
# and % of COMM groups responding to root health issues	6	1 – (A)
Number and percent of active ttC CHW AND # and % of trained and functional Community Health Workers/ Community Health Volunteers/Home Visitors/Peer Educators (providing health services at the household level) by gender	716 (42.14%)	1 – (A)
Prevalence of stunting in children under five years of age	42.43%	3 – (C, D & E)

Prevalence of underweight in children under five years of age	22.13%	3 – (C, D & E)
Prevalence of wasting in children under five years of age	2.27%	3 – (C, D & E)
# and % of children 0-5 months of age exclusively breast fed in the last 24 hours by gender	450 (37.53%)	3 – (C & E)
# of pregnant women receiving micronutrient supplements	9	1 – (E)
# and % of children aged 6 - 59 months with SAM and/or MAM participating in CMAM programs (SC, OTP, SFP) who have been rehabilitated	6,772	2 – (D & E)

3.3.5 Progress Description

Angola faced several crisis in the health system in FY17 ranging from recurrent stock-outs of medical supplies, malaria endemic, and yellow fever outbreak. With funding from Exxonmobil and the WV partnership, WVA was able to support eight public health facilities in two provinces to help the government respond to the endemic. A development project was also funded in FY17 by Global Fund on malaria treatment in under five children in six provinces and prevention advocacy of preventable diseases in nine provinces. Trainings were conducted at large scale with support from UNICEF, MoH, Ministry of Administration and Territory through FAS, WVA sub-recipients as well as community willingness to attend.

The Ministry of Health was the implementing partner in all projects, while various WV support offices, UNICEF, multi-lateral donor institutions such as US, Canada and WVHK were funding partners. Local level advocacy was conducted in all project areas where CVA model was used to engage on child health issues. WVA successfully engaged and reflected on the standardized way of forecasting caseload for management of moderate malnutrition programs together with key emergency partners. WVA contributed to standardization of the caseload estimation process for moderate acute malnutrition program using case studies from other countries.

The SAF projects realized greater achievements in nutrition interventions as the projects targeted high numbers of pregnant and lactating women and children under 5 years with agro nutrients, plumpy nut, plumpy sup, F100 and F75. Men and women were trained on equitable participation and decision making in household consumption of nutritious foods.

The SAM and MAM outputs were attained through leveraging on Gift in Kind (GIK) resources of 8,266 boxes of plumpy nut were distributed and benefited 15,506 SAM children (1,238 being girls and 1,013 being boys), 5,111 boxes of plumpy sup boxes of plumpy sup were distributed and benefited 9,586 SAM children (1,651 being girls and 1,350 being boys), 200 boxes of F100 benefiting 750 children and 200 boxes of F75 benefiting 3,428 children. The projects conducted awareness raising for health workers on disability and the need for social inclusion in programming. The WASH program has been supporting inclusive sanitary latrines and boreholes for schools in WV project areas. The main component was ensuring that latrines would cater for menstrual hygiene facilities and the boreholes for pupils´ hand washing.

3.4 Enablers

ENABLERS

LIVELIHOOD

Strategic Objectives

1) Ensuring that 250,000 children live in a safe environment and experience the love of God;
2) Extend and enrich education services to 250,000 vulnerable children; and,
3) Improve the Health and Nutrition status of 2,500,000 most vulnerable children.

Indicators

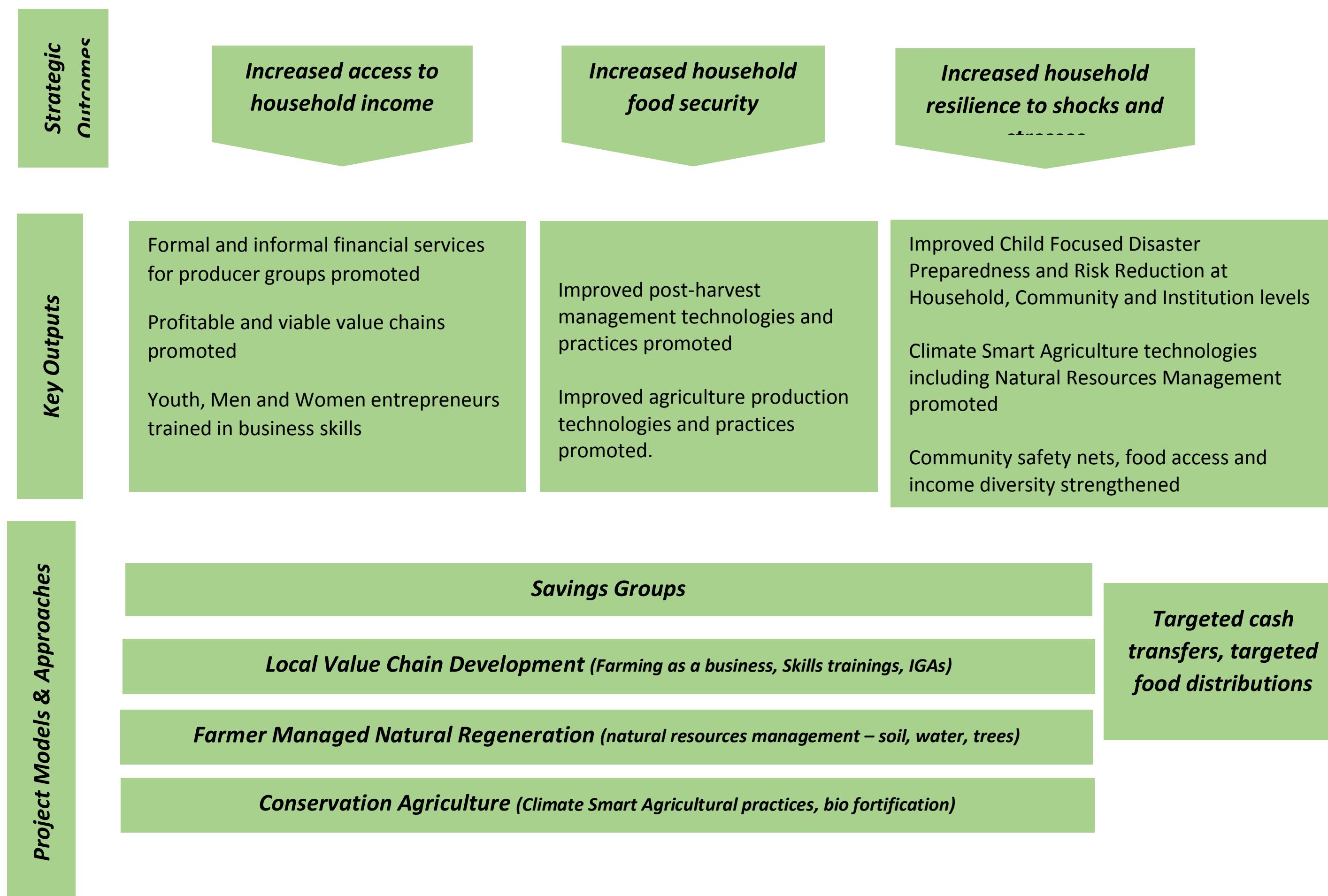
- Adolescents develop hope and skills for a productive future.
- Families and children have reasons and resources to be in school
- Children are well nourished and free from hunger
- Families with children have adequate and resilient livelihoods, income and assets.

3.4.1 SUMMARY OF LOGIC CHAIN

Angola has been experiencing unequal distribution of its wealth which has caused 77.4% of its population experience multiple forms of poverty. With the high poverty levels also influenced by low intervention by social actors due to government unfavorable policies which saw a lot of social actors out of the country coupled with less government investment into the social sector, has seen a lot of Angolans deprived from the right to education, health, faith development and protection to natural disasters. The lack of education and recreation centers for most of the children, has caused early marriages which is also assumed to have increased infant mortality rate.

To contribute to the reduction of these problems WVA used in FY the project models and approaches in the figure below.

3.4.3 Project Approaches & Key Outputs



- Wealth distribution is uneven with approximately 77.4% of Angolans experiencing multiple forms of poverty.
- Angola has the highest child death among the under-five with 157 deaths per 1,000 live births, comparable to other countries between 130 and 139 deaths per 1,000 children born.[17]
- Angola has the 3rd highest rate of child mothers with 170 births per 1000 women aged 15-19.[18]
- 27% of young people are illiterate. In rural areas this increases to 60%.[19]
- 2% of rural girls attend secondary school, rising to 28% of girls living in urban areas.[20]

[17] https://www.theguardian.com/society/2015/dec/30/born-lucky-world-bank-reveals-life-expectancy-rates-for-todays-infants

[18] https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_Reproductive_Paper_20160120_online.pdf

[19] http://www.unesco.org/education/GMR2006/full/chapt7_eng.pdf

[20] http://en.unesco.org/gem-report/sites/gem-report/files/regional_overview_SSA_en.pdf

- 37% of children are registered at birth, however this ranges from 15-69% depending on where children are born.[21]
- In Africa, the average distance to a health post is 8km. In Angola, it's more than 20 km. On arrival, only 75% of health units are considered functional with 10% reporting access to potable water.[22]
- The El Nino induced drought had negatively affected rural population by increasing proportion of households without access to safe and adequate water in the Southern part of the country due to the drying up of protected sources that became seasonal. Inevitably, the majority of households in rural areas changed their main source of water for domestic and livestock use due to drying up or lower levels of water sources.
- Since the economic crisis, the country fail into collapse such that all funding partners which could contribute to this objective had cuts in their budgets. The prices of common commodities continued to be higher than normal as informal foreign exchange rate the only source was 135% higher than the formal rate.
- The accumulated rainfall totals for the period 2014 to 2017 rainfall seasons showed extreme dryness for the greater part of the country[23]. Most of the country received at least one dry spell of more than 10 days. Areas in the southern part of Benguela, Cunene and Huila were the most affected with losses of livestock.
- Access and entitlement to land remained key issues for Angolans who work in agriculture and thus directly dependent on land rights.

3.4.4 SUMMARY OF KEY ACHIEVEMENTS

WV Angola's focus in livelihoods interventions, is on the ability of families to adequately and reliably provide for their children and thereby reaching other child well-being targets. When parents or caregivers can provide for their children, more children are well-nourished, more children have access to clean water, improved sanitation and needed health care (and are thereby protected from infection and disease), more children are able to attend and complete school (and learn to read by age 11), and more children are cared for and have hope for the future. Table 1 below presents a summary of key achievements that significantly provide an enabling environment for attainment of strategic priorities.

Table 1: Key of Achievements

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[21] https://www.unicef.org/infobycountry/files/UNICEF_Angola_COAR_2015_ENG.pdf

[22] http://www.who.int/hac/crises/ago/background/Angola_Dec05.pdf
https://www.cmi.no/publications/file/4319-health-services-in-angola.pdf
https://books.google.co.ao/books?id=JLETx00_YlcC&pg=PA117&lpg=PA117&dq=Average+distance+to+health+facilities+in+Angola&source=bl&ots=t4A1zbn66S&sig=T01ybCpsW0eSwSWm0ReWDwPu4O8&hl=pt-PT&sa=X&redir_esc=y#v=onepage&q=Average%20distance%20to%20health%20facilities%20in%20Angola&f=false

[23] http://documents.wfp.org/stellent/groups/public/documents/ena/wfp289520.pdf

Table 1: Key Achievements

Output Indicator	***# of Projects***	***Funding Source***	***FY17 Achievement***	***Key Partners***
LIVELIHOOD				
Number of households with sufficient diet diversity	4 – (C, D, E & F)	PNS	42,631	Ministries of Agriculture, Fisheries, IIA, IDA, EDA, UNICA, MoH, DW, Banks, OMA, Local associations, Churches and Local NGOs.
Proportion of households with one or more 'hungry months' in the previous 12 months	2		85.99 %	
Proportion of households with a secondary source of Income	2		37.1%	

Indicator: Proportion of households with sufficient diet diversity

In 2015 Securing Angola´s Future (AIF) project contributed to this indicator. A non-LQAS measurement was used and 14% of households in the target area were reported to have a sufficient diet diversity which had an improvement to 53.46% in 2017 using the same measurement type. The other projects that contributed to this indicator were ECHO, SAF and Women Entrepreneurs and data was collected using a non-LQAS for the three projects. For the Women Entrepreneurs project a sample was selected and it was reported that 50% of the beneficiaries had a sufficient diet diversity while the other two projects just reported the number of beneficiaries who reported to have had a sufficient diet diversity. It is not possible to compare between locations as our project funding settings is in a such a way that a project funded for a certain location will not have same characteristics to another in another location with a different donor.

Indicator: Proportion of households with one or more 'hungry months' in the previous 12 months

Two projects contributed to this indicator being the AIF and Women Entrepreneurs projects. The AIF project carried out a baseline and an evaluation in 2015 and 2017 respectively indicating that there was a reduction of almost 25% of populations with hungry months being from 44% to 19%. The Women Entrepreneur project did not collect data on this indicator in the previous years but the non-LQAS carried out in FY17 indicated that only 9% of the sampled households had one or more hungry months in the previous 12 months. A comparison between projects or locations is not made as the projects contributed to this indicator are not similar due to different donor requirements.

Indicator: Proportion of households with a secondary source of Income

Two projects contributed to this indicator. The AIF project carried out a baseline in 2015 which indicated that 47.06% of the sampled had a secondary source of income compared 49.65% during the evaluation in 2017 recording an increase of 2.6%. A non-LQAS carried out by the Women Entrepreneur reported that 25% of the sampled (women) had a secondary source of income.

MOST VULNERABLE CHILDREN

Who are they?	Vulnerability & evidence	Why are they vulnerable?	How is WV responding/ Actions decisions made to address
Children with disabilities	Children with disability are not able to enrol in school due to inaccessible facilities and no special teachers to attend to them.	Toilets and water facilities are not inclusively designed and children with additive or sight problems do not go to school because there is no teacher to attend to them.	Working with local authorities, ramps and low stand pipes were designed and disability inclusive toilets constructed through WASH. Although no project in education through meetings with local partners WVA is sensitizing on the inclusion of disabled children into the system.
Children leaving in refugee camps or draught areas	Children in these areas have no adequate meals to give them energy to go to school, have no improved water and have less or no access to social services.	Caregivers and children have no adequate meals and hence leaving children malnourished, no energy to walk to schools which are also to far, have no appropriate shelter and access to medical services.	Working with local, national and international partners to mitigate and lower effects based on initiatives raised by the affected populations.

SUSTAINABILITY

WVA established collaborative partnerships with the ministries of Agriculture, Health, IIA, EDA, provincial and municipal government institutions, other International and National NGOs, Local Associations and social welfare groups to ensure that the needs of most vulnerable children are met.

To guarantee project initiatives sustainability, WVA partnered with; UNACA, ANDRA-Angolana, Development Workshop (DW), local governments, traditional authorities, MoH, MoA, Municipal Nutrition departments, banks, cooperatives and associations to build on local initiatives and encourage the use of local resources.

Key Learnings and Recommendations

Key Learning	**Recommendations**
One of the major current challenges of local associations and cooperatives is the lack of resources and skilled personal with the groups to train others on resilience. Groups within communities have been seen to have interest in	Build the capacity of local institutions to be the building blocks of communities.

developing their communities for the wellbeing of children but due to lack of leadership to motivate local initiatives, these are not implemented. Experience from different projects members was by WVA and good practice encouraged to be transmitted to other locations/groups.	
It is essential that WV works with local partners to ensure a multiplication factor and guarantee the long term sustainability of project.	WVA to strengthen its partnership with agricultural, health and education departments and child protection institutions at all levels in the implementation of its projects.

3.4 Enablers

ENABLERS

Strategic Objectives

1) Ensuring that 250,000 children live in a safe environment and experience the love of God;
2) Extend and enrich education services to 250,000 vulnerable children; and,
3) Improve the Health and Nutrition status of 2,500,000 most vulnerable children.

Indicators

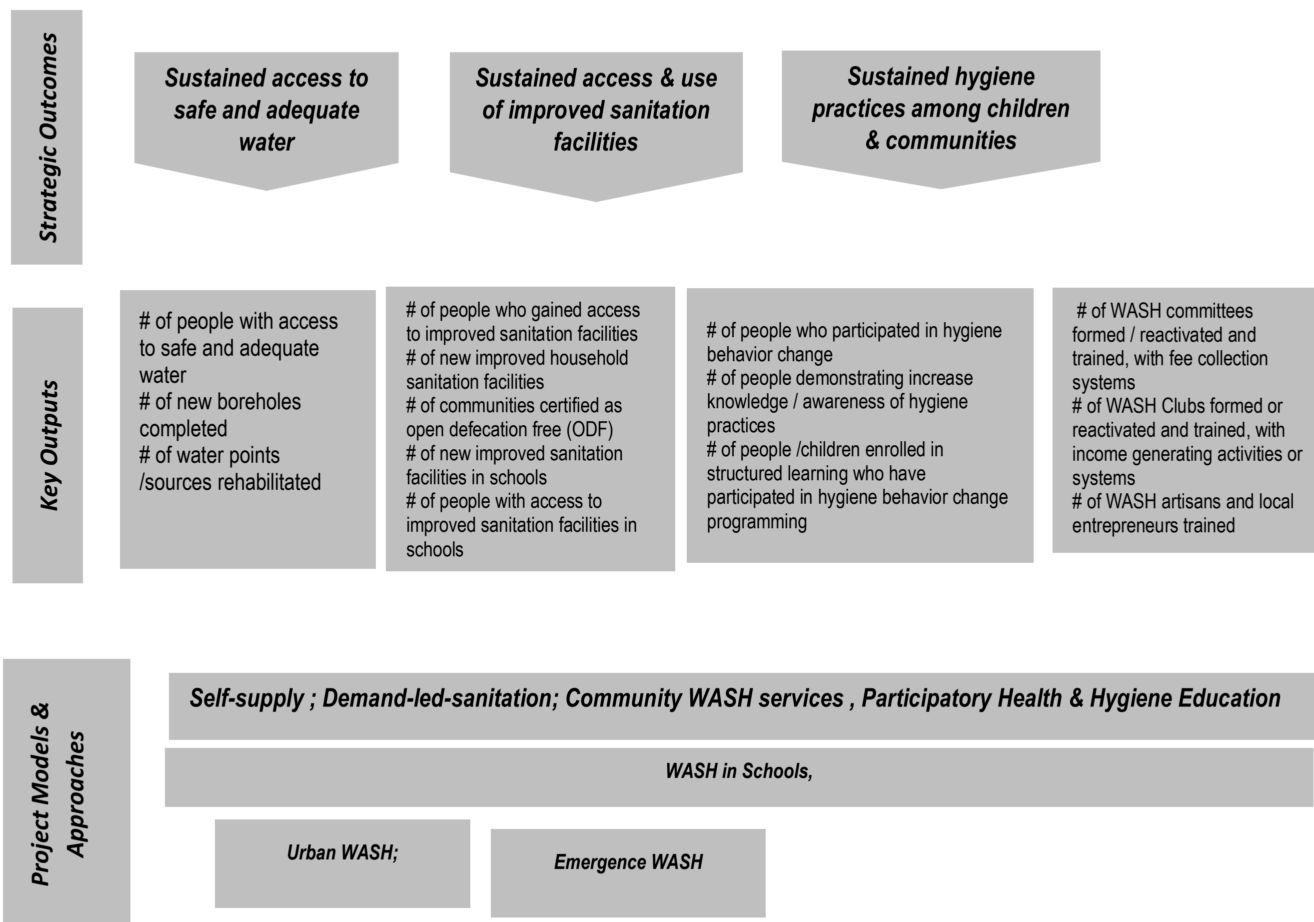
- Children enjoy good health.
- Children are educated for life.
- Children experience the love of God and their neighbors
- Children are cared for, protected and participating.

3.4.1 SUMMARY OF LOGIC CHAIN

Almost half of the Angolan population have no access to improved water and sanitations facilities which has for many years contributed to many deaths mainly in children and their caregivers. The lack of improved water and sanitation facilities has also contributed to the low levels of child education in Angola.

To contribute to the reduction of these problems WVA used in FY the project models and approaches in the figure below.

3.4.3 Project Approaches & Key Outputs



49.3% of Angolans do not have access to improved water & sanitation facilities.[24]

- In Africa, the average distance to a health post is 8km. In Angola, it's more than 20 km. On arrival, only 75% of health units are considered functional with 10% reporting access to potable water.[25]
- The El Nino induced drought had negatively affected rural population by increasing proportion of households without access to safe and adequate water in the Southern part of the country due to the drying up of protected sources that became seasonal. Inevitably, the majority of

[24] https://www.wsp.org/sites/wsp.org/files/publications/CSO-angola.pdf

[25] http://www.who.int/hac/crises/ago/background/Angola_Dec05.pdf
https://www.cmi.no/publications/file/4319-health-services-in-angola.pdf
https://books.google.co.ao/books?id=JLETx00_YlcC&pg=PA117&lpg=PA117&dq=Average+distance+to+health+facilities+in+Angola&source=bl&ots=t4A1zbn66S&sig=T01ybCpsW0eSwSWm0ReWDwPu4O8&hl=pt-PT&sa=X&redir_esc=y#v=onepage&q=Average%20distance%20to%20health%20facilities%20in%20Angola&f=false

households in rural areas changed their main source of water for domestic and livestock use due to drying up or lower levels of water sources.

- 54.7% of schools in Angola do not have access to adequate sanitation facilities and
- 68.6% of schools in Angola do not have access to hand washing facilities.
- 72% of the schools have no access to menstrual hygiene facilities;
- only 58% of girls access lockable latrines;
- only 23% of the schools have School Health Masters trained in menstrual hygiene

The UNICEF Snapshot of WASH in Schools in eastern & Southern Africa Report 2013, showed

- 53% of schools have access to adequate water supply.
- 45% of schools have access to adequate sanitation.
- 13% of school provide hand washing facilities.

The situation in Angolan schools calls therefore for interventions to increase the water supply, facilitate access to adequate sanitation. Furthermore Hand washing facilities are limited in schools as well as poor menstrual hygiene. Limitation in access to menstrual hygiene further exacerbates absenteeism for girls in school due to lack of privacy and poor access to menstrual hygiene.

3.4.4 SUMMARY OF KEY ACHIEVEMENTS

(Have a brief narrative) eg WV Angola's focus in livelihoods interventions, is on the ability of families to adequately and reliably provide for their children and thereby reaching other child well-being targets. When parents or caregivers can provide for their children, more children are well-nourished, more children have access to clean water, improved sanitation and needed health care (and are thereby protected from infection and disease), more children are able to attend and complete school (and learn to read by age 11), and more children are cared for and have hope for the future. Table 2 below presents a summary of key achievements that significantly provide an enabling environment for attainment of strategic priorities.

Table 2: Key of Achievements

Output Indicator	***# of Projects***	***Funding Source***	***FY17 Achievement***	***Key Partners***
Water				
Number of HHs using a basic drinking water facility using an improved drinking water source within 30 minutes roundtrip of household, including queuing time	2	PNS	54,893	Ministry of Water and Energy, DW, Local community WASH
Number of educational facilities with functional basic (improved) drinking water source	1	PNS	11	

Number of health facilities with a functional and accessible basic (improved) water source on premises	I	PNS	I	committee, National Dictorate of Civil Protection, MoH and MoE.
Sanitation				
Number of HHs using a basic sanitation facilities that are improved and not shared by two or more households	I	PNS	63,594	

Two projects have contributed to the above indicators being the WASH-WVUS and the Integrated Emergency nutrition and WASH Response, the late having contributed to first indicator only.

MOST VULNERABLE CHILDREN

Who are they?	Vulnerability & evidence	Why are they vulnerable?	How is WV responding/ Actions decisions made to address
Children with disabilities	Children with disability are not able to access water points and sanitations facilities due to inaccessible facilities.	Toilets and water facilities are not inclusively designed and children disability are unable to access them let it be in schools, health facilities or communities.	Working with local authorities, ramps and low stand pipes were designed and disability inclusive toilets constructed through WASH. Although no project in education through meetings with local partners WVA is sensitizing on the inclusion of disabled children into the system.
Children leaving in refugee camps or draught areas	Children in these areas have no adequate improved water and sanitation facilities due to emergency or disasters.	Children have no access to improved water and sanitation and hence exposing them to preventable diseases.	Working with local, national and international partners to influence decision makers to take services near these populations.

SUSTAINABILITY

WVA established collaborative partnerships with the ministries of Energy and water, DW, Local community WASH committee, National Dictorate of Civil Protection, MoH and MoE to ensure that the needs of most vulnerable children are met.

To guarantee project initiatives sustainability, WVA partnered with; DW and local WASH committes, local governments, traditional authorities and MoH to build on local initiatives and encourage the use of local resources for the set-up and maintance of water points and sanitation facilities.

Key Learnings and Recommendations

Key Learning	Recommendations
When water bone diseases are explained to rural populations, the impact can be seen when people are asked to participated in WASH activities.	Although funding of different projects to WVA is not an easy task to achieve, the office can negotiate with the government where possible to implement complimentary projects in the same intervention area to consolidate WVA efforts.

4. Emergency Response

4.1 Description of Disaster

Angola experienced two disasters in FY17 one being a severe drought in the Southern part of the country in 2015 with effects extended to 2017 and the other refugees in 2017 as a result of a conflict from the neighboring Democratic Republic of Congo (DRC).

The extended drought caused the unprecedented food insecurity humanitarian emergency. The El Niño phenomenon, a complex weather pattern resulting from variations in ocean temperatures in the equatorial Pacific, characterised by erratic, unpredictable and suppressed rainfall. This resulted in severe dry areas in many parts of Angola with the southern region being mostly affected. This led to reduced access to safe water and reduced livelihood (crop and livestock) capacities, which was worsened by a rapid decline in basic service provision caused by the country economic crisis resultant from oil price fall on the international market and reduced purchase power of citizens caused by the 39% inflation. The Angolan government did not declare a "state of emergency" as a result of drought but LWF reports that 14% of the Angolan population had been affected by droughts from 2014[26] and these required food, health, water and nutrition assistance. Although households tried looking for alternatives for their livestock by moving kilometres and kilometres in search of pasture and water, more than 360,000 heads of cattle have been reported dead.

To increase community resilience and prevent further cases of acute malnutrition, the project distributed improved seeds to 6,889 mothers with SAM and MAM children, in partnership with Provincial Departments of Agriculture.

World Vision's CHA's provided tablets of Albendazole, donated by World Vision USA, for the last massive measles and deworming campaign in December, which benefitted 315,353 children in Huila province.

4.2 World Vision's response:

World Vision Angola's Nutrition in Emergencies (NiE) activities

[26] https://www.lutheranworld.org/content/emergency-drought-angola-and-namibia

In an attempt to combat and treat children under 5 with acute malnutrition, World Vision's Nutrition in Emergencies (NiE) activities focused on the prevention of acute malnutrition and micronutrient deficiencies and treatment of acute malnutrition through CMAM programs; the promotion and protection of Infant and Young Child Feeding (IYCF) through behaviour change and communication messages (BCC); and building capacity of the MoH nurses working in the in- and outpatient nutrition centres to manage and treat children with malnutrition and training of community health volunteers. NiE was implemented with ECHO funding in the provinces of Huila and Cunene.

The project partnered with the Ministry of Health (MoH) in response to the El-Niño phenomenon to identify, refer, treat, and counsel families with children diagnosed with Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM). Project staff and partners trained and supervised 255 nurses from both in-patient and outpatient treatment centers in 10 Municipalities.

As a result of the above action, a total of 8,240 children diagnosed with SAM and 6,805 diagnosed with MAM were enrolled into the outpatient treatment program and supplementary feeding program respectively. From the total SAM number of children enrolled into the treatment program, 1,445 (17.5%) were first enrolled into the inpatient treatment program because they had medical complications or edema. Then after meeting the exit criteria they were enrolled in the outpatient treatment program.

To link the community to the health facility, the project trained 327 Community Health Agents (CHAs). As a result, the CHAs screened 157,832 children and provided Infant and Young Child Feeding counseling to 26,810 mothers and caregivers of children under the age of 5 years. In addition, malnourished children identified during community screenings were referred to health facilities and enrolled in the appropriate (SAM or MAM) treatment program. During the reporting period, program data from community screening indicated a noticeable decrease in malnutrition. The project recorded a monthly GAM rate of 9%.

Refugee Emergency Response

WVA responded to this emergency through the management of food and non-food commodities in collaboration with partners. The food and non-food commodities were supplied by UNHCR and WFP to WVA after evaluating its potential in handling the same. With the tripartite agreement, WVA successfully carried out: warehouse management, secondary transportation, distributions of food and non-food items, and support to the relocation of refugees to new settlement in Louva.

Food Distributions:

Food distributions to the refugees took place in the two refugee camps at Louva and Cacanda. Maize, Beans, Oil and Salt were distributed to all refugees while Super Cereal plus and CSB plus were provided as a blanket supplementary ration to all children between the aged of 6 – 23 months and pregnant/lactating women. A total of 24,622 refugees were reached with a cumulative total of 409.577.10 MT of assorted food commodities.

Relocation of Refugees to new settlement Lovua

The relocation process proceeded slower than planned. The lack of heavy machinery to open primary and secondary roads within the camp continued to delay site development and installation of basic facilities to receive refugees. The current refugee population in Lovua settlement stands at 3379 (only 11%) of the registered Congolese refugee population in north Angola. A further 7200 (+/-) refugees continue to live in Cacanda. This number has been increased because same refugees came in to be installed in Cacanda center from Dundo town, and 19.421 in Dundo town pending further relocation to Lovua. The settlement has a total planned capacity for approximately 30,000 refugees, in order to effectively respond to needs of the refugees living in Lunda Norte.

4.3 Contribution to resilience

Drought has both direct and indirect impacts. Drought directly affects production, lives, health, livelihoods, assets and infrastructure that contribute to food insecurity and poverty. However, the indirect effects of drought on environmental degradation and reduced household welfare through its impact on crop and livestock prices could be larger than its direct effects.

It is assumed according to our interactions with populations in our implementation areas that at least 15% of children had dropped out of schools because of lack of energy as a result of lack of water and food to walk to school and concentrate, and/or because they needed to help their families sustaining their livelihoods. Girls were mostly affected because they had to fetch for water while boys were affected by moving long distances to feed livestock leaving them with no time to return home and go to attend classes. Children in project implementation areas show that these difficulties have been minimized and they showed a slightly different scenario to those non-project areas who continue with the same problems.

Before the WV´s projects implementation, children's nutrition status was low but during the implementation phase, household food consumption score in project areas has shown improved meal quality and with at least 2 meals a day of a diverse option of food groups to choose from. Parents were able to buy food for their children due to increased income resulted from improved crops distributed by WVA and reported cases of malnutrition reduced compared to same periods of the previous years of drought.

WV Angola will build on the previous success with EC's awards to strengthen the governance, organization and functioning of Consultation Forums and build the capacity for representation, gender equality, negotiation capability and internal governance of civil society organizations. Sustainable economic development will be promoted through agriculture value chain development, land tenure, nutrition sensitive agriculture, village banking for women entrepreneurs and social enterprises.

5. Reflections and Conclusions

The FY17 child well-being report presents an opportunity for WVA to pause and reflect on the effectiveness and impact of the office´s programming on the most vulnerable children. Key lessons drawn from the process of putting this report together (i.e. from data gathering, analysis and narrative) not only enhance the reporting process but also serve to redesign our M&E system in projects to respond to both donor and WV partnership requirements. In consequence this will strengthen evidence-based decision-making likely to lead to the sustained well-being of children. The report also encourages and allows project managers to focus their programming and interventions towards a sustained child well-being.

Being a donor focused office, WVA has been concentrating on donor indicators which in some cases do not align with WVI standard indicators. An effort was made to better track, aggregate and report project inputs and outputs, particularly through the adaptation of some donor indicators similar to WV standardized output indicators. However, the lack of a harmonized monitoring system, coupled with highly localized designs and M&E plans, and wide diversity of donor requirements and variable program time frames challenge aggregation and learning at a program-wide scale. With the strategy review and vulnerability mapping, WVA started to review donor indicators to align with WV´s standard indicators.

Although this the third CWBR for WVA, it is constrained in the ability to progressively compare statistics over time as some of the projects did not have a baseline to allow the measurement of impact on child well-being outcomes. Non-LQAS have mostly been adapted to report projects´ achievements. For future reports to provide stronger analysis and contribute to evidence based programming, WVA needs to influence its donors to approve budget allocations to improve the focus of its programming, streamline its DME systems and invest in capacity for capturing and utilizing data in a manner that is more meaningful for program learning and evidence.

ANNEXES

Annex 1

Angola Strategy emm.docx

Annex 2

WVA Organization Structure.docx