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OA/ID Number: 21064

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Folder Title:
Angola

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#3 of 14

Angola
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Rwanda

OA # 21064
VARA # 18285

declined 4/14 on travel

April 13, 2000

TO: AID - Dick McCall (216-3455)
AID/AFR - Vivian Derryck & Bill Jeffers (216-3233)
AID/BHR - Hugh Parmer (216-3397)
AID/OTI - Bob Kramer (216-3406)
ONAP - Sandy Thurman (456-2439)
DOD/OSD - Bear McConnell (703-695-4620)
Corps of Engineers - Judy Reid (761-0824)
USDOC - Ed Casselle (482-6083)
- Eric Henderson (482-5198)
USDOC/CLDP - Nnamdi Ezera (482-3244)
USDA - Frankie King (720-7779)
Treasury - Ed Barber (622-1432)
DOE - George Person (586-1180)
SBA - Tanya Smith (205-7272)

FROM: NSC - Gayle Smith (for Gayle Smith)

SUBJECT: Meeting on Deliverables for Angola BCC

Since the discussion on SADC deliverables at our April 13 meeting took longer than anticipated, we have had to schedule another meeting to address deliverables for the BCC meeting in Angola.

I therefore would like to meet with you on Wednesday, April 19, at 10:30 a.m. in Room 6245 of Main State to discuss our key objectives and possible deliverables for the U.S.-Angola BCC (May 4-5). Attached is the agenda for the BCC and a proposed set of deliverables we would like to discuss on Wednesday. I also encourage you to come with proposals. We do not have much time to nail down what we will be prepared to put on the table next month, so this meeting is important.

Please feel free to bring others from your agency as necessary to make this a productive session. For those of you outside State, please confirm your attendance to Sharon Rogers in AF/S on 202-647-9836 so that we may facilitate your entry into the building. I look forward to seeing you on Wednesday.

Attachments: 1) BCC Agenda
2) Notional Deliverables

Draft Agenda for BCC Meeting
Luanda, May 4-5

May 2

1945 Arrive Luanda

May 4

0900 - 0945 Opening Plenary

-- Welcoming Remarks/Comments - FM Miranda (tentative)

-- Opening Comments - A/S Rice
- NSC Smith

Panel on Economic Issues

1000 - 1230

-- Economic Reform (Lead GRA)
-- Investment Climate
-- Private Sector Issues

1230 - 1430 **LUNCH**

1430 - 1530

-- Potential areas for USG Technical Assistance

- Capacity building in Macroeconomic management
- Tax Collection
- Commercial Code
- Customs Administration
- Banking Sector Reform

1545 - 1830

Panel on Social/Humanitarian Issues

-- HIV/AIDS (Lead GRA);
-- Public Private Initiative on HIV/AIDS
-- IDP's/Humanitarian Relief (Lead GRA)
-- Poverty Alleviation

1930 RECEPTION (Hosted by U.S. Angola Chamber, tentative)

May 5 (Concurrent Sessions)

Panel on Political Issues

0900 - 1200

-- Internal Developments (Lead GRA)
-- Demobilization/Civil-Military Operations (Lead GRA);
-- Elections (Lead GRA)
-- Creating Political Space for UNITA
-- Dealing with the Press/Freedom of Expression

0900 - 1100

-- Meeting between U.S. and Angolan Private Sector Reps.

1200 - 1400 LUNCH

1400 - 1500 (Concurrent Sessions)

Panel on Regional Security

-- Conflict in DROC, Congo-B, Relations with Neighboring States

Panel on Economic Development

-- Infrastructure Development, Angolan priorities (Lead: GRA)

1515 - 1600

-- Closing Plenary/Next Steps

BCC - GRA Deliverables Wish List

(N.B. Those "deliverables" from the GRA wish list below that we choose to provide would need to be funded out of ESF, DA, or ATRIP.)

1. Training in economic management, fiscal policy, human resource capacity development, and design of econometric models for developing economies.

2. Guidance on reducing tax evasion and raising government revenue.

3. Assistance in streamlining financial sector.

4. Help in modernizing the financial system, and establishing a bank regulatory regime.

(Treasury potentially could provide expertise to assist in most aspects of items 1 - 4. One exception would be the request for help in human resource capacity development. Two resident experts, at a minimum, at a cost of about $500,000 per head, would probably be required. Assuming they are assigned to Angola for a year, the cost for this group of deliverables would be $1 million)

--

5. Assistance in privatizing and restructuring parastatals.

6. Technical assistance to support privatization of the insurance sector.

7. Help in utilizing humanitarian assistance to support rehabilitation and economic reform (such as the GRA land distribution program for IDP's)

(USAID could potentially provide consultants to address items 5 - 7 as part of a broader economic growth and development program. The cost would be approximately $)

--

8. Assistance in commercial law reform and development of corporate accounting standards.

9. Assistance in creating a favorable investment climate in non-oil sectors.

10. Support in encouraging development of small and medium sized businesses.

(USDOC could facilitate item 8 through its CLDP program. Estimated cost for a CLDP program to reform the commercial code is $400,000. SBA could possibly provide expertise for item 10. Estimated costs likely would be similar to the CLDP, $400,000.)

--

11. Technical expertise to develop the agricultural sector.

12. Programs to develop cattle farming, formerly a large part of Angola's agricultural sector.

13. Professional training in natural resources management, including alleviation of drought and desertification.

(USDA would be the logical agency to respond to items 11 - 13. However, until the GRA provides additional specificity about the kinds of assistance it envisions, it is difficult to estimate the costs of proposed U.S. support.)

--

14. Technical assistance to rehabilitate basic infrastructure such as roads, transport systems, hospitals, dams, bridges, railroads and airports, and telecommunications.

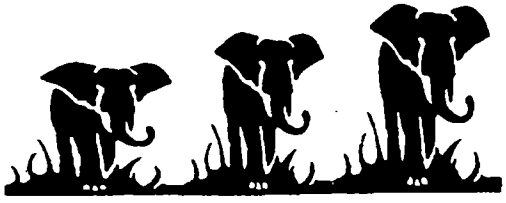
15. Technical assistance to address such health care needs as TB, HIV/AIDS, Trypanosomiasis, and malaria, including medical training, laboratory development, diagnostic kits, medicines, clinics, blood banks, and public education (particularly for HIV/AIDS), AIDS hospital wards, radiological/laboratory facility in Luanda and disease prevention programs.

(Here again, the scope of the request is so broad that until the GRA narrows its focus or the USG conducts a detailed needs assessment, it would be difficult to place a dollar figure on potential U.S. assistance.)

Washington, D.C. 20520

declined

OFFICE OF SOUTHERN AFRICAN AFFAIRS (AF/S)
TELECOPIER TRANSMITTAL



DATE: April 12 NO. OF PAGES (INCLUDING COVER): 2

TO: SEE Attachment

FAX NUMBER:

FROM: J Sequeira PHONE: 72836

COMMENTS: Correction: Meeting date is THURSDAY, April 13. We look forward to seeing you on Thursday. AS disregard Seeing you on Friday. Thanks

Sentence ↑

THE FAX NUMBER FOR THE OFFICE OF SOUTHERN AFRICAN AFFAIRS IS (202) 647-5007.

April 10, 2000

TO: AID - Dick McCall (216-3455)
AID/AFR - Vivian Derryck & Bill Jeffers (216-3233)
AID/BHR - Hugh Parmer (216-3397)
PRM - Julia Taft
NSC - Gayle Smith & Nora Dempsey (456-9260)
PM - Bob Beecroft & Gio Snidle
GHD - Don Steinberg
PM/HDP - Pat Patierno
INL - Rand Beers & Jim Callahan
E - Anne Pence
USTR - Rosa Whitaker
ONAP - Sandy Thurman (632-1096)
DOD/OSD - Bear McConnell (703-695-4620)
DOD/EUCOM - Max Alston
Corps of Engineers - Judy Reid (761-0824)
USDOC - Ed Casselle (482-6083)
USDA - Frankie King (720-7779)
Treasury - Ed Barber (622-1432)
DOE - George Person (586-1190)
SBA - Tanya Smith

FROM: AF - Susan Rice SER

SUBJECT: Meeting on Deliverables for SADC Forum and Angola BCC

I would like to meet with you on Thursday, April 13, at 2:30pm in Room 3519 of Main State to discuss our key objectives and possible deliverables for both the second U.S.-SADC Forum (May 10-11) and the U.S.-Angola BCC (May 4-5). Based on the agendas for theses two meetings (attached), we have some proposals (attached) which we would like to discuss on Friday. I also encourage you to come with proposals. We do not have much time to nail down what we will be prepared to put on the table next month, so this meeting is important.

Please feel free to bring others from your agency as necessary to make this a productive session. For those of you outside State, please confirm your attendance to Sharon Rogers in AF/S on 202-647-9836 so that we may facilitate your entry into the building. I look forward to seeing you on Friday.

Attachments:
1) Forum Agenda
2) BCC Agenda
3) Notional Deliverables

April 11, 2000

FAX TO:	**NSC** - Nora Dempsey	456-9260
	USTR - Joe Ripley	395-4505
	USDOC - DAS Ed Casselle	482-6083
	USAID - DAA Verne Newton	216-3008
	- Bill Jeffers	216-3233
	- Mike Fritz	
	- Pat Jordan	
	- Dillon Banerjee	
	ONAP - Dir. Sandy Thurman	456-2439
	Treasury - Beth Urbanas	622-1432
	- Michele Budington	
	EXIM - Gloria Cabe	565-3505
	OPIC - Sam Smoots	408-5145
	Corps/Engineers, Judy Reid	761-0824
	DOD - Max Alston	703-588-8094
	USDOC/AF - Jerry Feldman	482-5198
	- Eric Henderson	
	STATE/PRM - Mary Lange	663-1061
	DOD/OSD/ISA - Adam Grissom	703-695-4620
	SBA - Tanya Smith	205-7272

FROM: AF/S: Deputy Director, Donald Booth

REMARKS: The SADC Forum/Angola BCC meeting scheduled for April 12 has been cancelled. We will meet again regarding planning for the SADC Forum and BCC on April 20, at 2:00 in room 3519 Main State.

Confirmed

April 28, 2000

TO:

NSC - Nora Dempsey (456-9260)
AID/AFR - Bill Jeffers (216-3233)
AID/AFR - Share Maack
AID/BHR - Richard Ragan (216-3397)
AID/OTI - Bob Kramer (216-3406)
ONAP - Sandy Thurman (456-2439)
DOD/OSD - Bear McConnell (703-695-4620)
Corps of Engineers - Judy Reid (761-0824)
USDOC - Eric Henderson (482-5198)
USDOC/CLDP - Nnamdi Ezera (482-3244)
Treasury - Ed Barber (622-1432)
DOE - Carolyn Haylock-White/George Person (586-1180)
SBA - Tanya Smith (205-7272)
EXIM - Gloria Cabe (565-3505)
OPIC - Sam Smoots (218-0183; 408-5145)

FROM: AF/DAS - Witney Schneidman WS

SUBJECT: Meeting on Deliverables for Angola BCC

Our discussion on BCC deliverables earlier this week had to be cut short, and I would like to pick up where we left off at a meeting on Wednesday, May 3, at 12:00 p.m., in Room 3519, Main State.

Attached is the proposed set of deliverables we began discussing. I would appreciate if you could review this list to identify those items your agency might be able to provide, and what it would cost to provide them. The estimates will enable us to get a better idea of what it would entail to support the potential deliverables we offer to the GRA.

Please feel free to bring others from your agency as necessary to make this a productive session. For those of you outside State, please confirm your attendance to Sharon Rogers in AF/S on 202-647-9836 so that we may facilitate your entry into the building. I look forward to seeing you on Wednesday.

Attachments: Deliverables List

Draft List of Potential Deliverables and USG Expectations
BCC, Luanda, May 25-26

Panel on Economic Issues

Potential Deliverables

- USDOC Commercial Law Development Program to revise commercial code and development of corporate accounting standards. This assistance will create a more favorable investment climate for the non-oil sector. (ESF Funding, $400,000)

- Training for key economic ministry officials in data collection and analysis linked to the IMF SMP, (USAID exploring)

- Technical assistance on revision of the foreign investment code (USAID)

- Continuation of USAID assistance to Ministry of Planning to refine the long-term economic model which enables testing of alternative investment scenarios. (USAID)

- USDA exploring the possibility of offering the Suppliers Credit Guarantee Program (SCGP) for use by Angolan importers. (USDA)

- USDA sponsor an Agricultural Trade Mission to Sub-Saharan include Angola to emphasize two way trade opportunities. (USDA)

USG Expectations

-- Adherence to the SMP Schedule to include bank reform, audits, better statistics and start of oil sector diagnostic.

-- Meet outstanding arrears due on payment to Mampeza Industrial for shipments of canned tuna of approximately $700,000.

-- Make military spending a transparent part of the National budget (at present USG unable to support Angola in IFI's)

-- Articulation of GRA priorities and goals to create a better investment climate

-- Ensure transparency and a market-oriented approach to the diamond market in Angola.

-- Set up dialogue with U.S. private business to address areas for growth and opportunities for use of private development fund.

-- GRA progress in privatizing the Angolan economy.

Panel on Social/Humanitarian Issues

Potential Deliverables

- Funding for humanitarian training for FAA liaison officers, UN and NGO community ($100,000 - USAID)

- Information, education and communication (IEC) pilot program on HIV/AIDS to begin this year, with FY 2000 funding of $1 million. Includes condom program. Pilot program starts in Luanda province. (USAID)

- USAID assistance to replicate pilot program elsewhere. (Explore oil company financing)

- An additional $500,000 for Displaced Children Orphans Funds for AIDS orphans and vulnerable children. (USAID)

- USDA allocation of $37 million in direct aid during FY 2000, in addition to World Food Program (WFP) resources (USDA)

- Under 416(b) and Title I Monetization programs, Angola has received $21 million in direct aid to finance small and medium-size economic projects and settlement of displaced people and refugees in the rural areas. (USDA)

- Reprogram $800,000 from mission funding to immediately initiate a reintegration program with the local NGO's, the Institute of Social and Professional Reintegration of Excombatants (IRSEM) and the Agency for the Development and Reconstruction of Angola. (USAID)

- Provide technical assistance and call upon the International Organization of Migration (IOM) to support GRA reintegration program. (USAID to confirm) (Note: PRM has $100,000 outstanding from FY97 funding to IOM for refugee repatriation in Angola, which could be programmed for this use)

- Through Food For Peace (FFP) provision of food and/or cash for work activities that support proposed reintegration program. (USAID).

- Using PRM funds, support UNHCR, IOM and NGO's to support humanitarian relief to Angolan refugees ($2 million; PRM to confirm, may link to outstanding $100,000 held by IOM, above)

USG Expectations

- Explanation of US Private Sector Experience and policies in Africa relative to HIV/AIDS (USDOC)

- GRA assumes more responsibility for the well being of Angolans and finance projects.

- Clear articulation of HIV policy by GRA

- Improve distribution of essential health supplies and drugs and vaccines

- GRA health projects to include clinics and clean water supply in newly occupied areas, such as Andulo and Bailundo

- GRA to start primary education system at the areas most critically impacted by recent fighting and in newly liberated areas.

- GRA set up a consultative group with private industry to assess use of social development funds and set priorities

- GRA meets goals articulated by UN to include repair of runways in Kuito, agreement on criteria for resettlement of IDP's, and clearance of IDP transit camps within six months

- Resolve NGO Visa and customs problems that hamper delivery of relief items and discourage international expertise.

Panel on Political Issues (State, NSC, DOD, USAID)

Potential US Deliverables

- Civilian Military Relations Training (DOD)

- Non-lethal IMET training to include language training and military justice (DOD, through State)

- Support fair electoral and political party processes and strengthening civil society participation (USAID)

USG Expectations

- GRA Progress on creating an open press law
- GRA initiates dialogue with NGO community
- GRA encourages open, public debates in political parties, press, NGO'S and church communities

Panel on Rebuilding Post-Conflict Angola

Potential Deliverables

- Presentations on of renewable energy and advanced energy technologies (DOE; no funding)

- Presentations on institutional and technical capabililities.

- Oil Spill Workshop (September/Location in Africa TBD) (DOE; no funding)

- Participation in Policy (August) Summer Institute at University of Arizona (mid-Level manager). (DOE; no funding)

- Public/private exchanges in energy sector, including at national laboratories, universities and utilities (DOE, no funding)

- DOE presentations on renewable energy and advanced energy technologies.

- Policy consultations and workshops on various topics, including regulatory reform and market restructuring (DOE, no funding)

- Farmer to Farmer program for Angola as part of a larger program, to include technical assistance in agribusiness development, credit and rural development (USDA)

USG Expectations

- GRA makes resources available for community based renewable energy projects

- GRA articulates plans and makes funds available for rebuilding former UNITA communities, such as Andulo and Bailundo.

- GRA develops reintegration strategy and employment opportunities for demobilized.

- GRA willingness to fund projects

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Collection: Clinton Presidential Records

Subgroup: National AIDS Policy Office

Series:

Subseries:

Document Title HIV/AIDS prevention program

Language: Portuguese

Folder Title Angola

OA/ID: 21064

11 pages

FAX TRANSMISSION

Agency for International Development
Office of Southern African Affairs

To: Cheryl B
White House AIDs Policy Office

From: Carole Palma
FAX: (202) 216-3233 Phone: 202-712-4790

Subject: Background Information on HIV/AIDS

Date: 10/11/00 No. of Pages: 26

Message: For the BCC Meeting on Angola.

Sent in 2 parts -
1st part - 12 pages
2nd part - 14 pages

ANGOLA AND HIV/AIDS

Key Talking Points

Angola's HIV prevalence rate is lower than the rates of neighboring Zambia, Namibia, Zimbabwe, and Congo, largely because of the isolating effects of the civil war. Nevertheless, Angola, along with Namibia and South Africa, was one of the only African countries to have experienced proportional increase in HIV prevalence rates of over 100 percent between 1994 and 1997.

- In 1998 an estimated 4 percent of the general population was HIV-positive.
- An estimated 200,000 Angolans are living with HIV—26,200 of them with AIDS.
- The highest HIV-prevalence groups are females 20 to 39 years old and males 20 to 49 years old.

AIDS Deaths More than 31,000 people have died from AIDS-related diseases since the beginning of the epidemic in Angola—8,000 of them in 1998.

Women and HIV/AIDS In 1998, 8 percent of pregnant women in Cabinda tested positive for HIV. According to two studies in Luanda, sexually transmitted infections in pregnant women are prevalent—1 in 3 for candidiasis, 1 in 11 for gonorrhea, 1 in 4 for chlamydia and 1 in 8 for genital ulcers.

Youth and HIV/AIDS More than 35 percent of all reported AIDS cases are young people 15 to 29 years old.

Children and HIV/AIDS Forty-eight percent of the population is under age 15. More than 5,200 children under age 15 are living with HIV/AIDS, and approximately 8 percent of all AIDS cases are under age 14.

Socioeconomic Impact About 90 percent of reported AIDS cases are adults 20 to 49 years old. Since this age group constitutes the most economically productive segment of the population, an enormous economic burden is created.

USAID/Angola did not receive HIV/AIDS funding for FY 1998. However, the mission is currently developing a new strategy that will strengthen child survival and other health-related activities. The operating environment of Angola and the Central Africa region has changed dramatically in the last few years, reflecting the U.S. State Department's decision to "deepen and broaden" the U.S. relationship with Angola.

National Response The civil war has devastated Angola's infrastructure and severely weakened its ability to respond effectively to the HIV/AIDS epidemic, which threatens to further erode the country's stability and development. In 1987 the Programa Nacional de Luta contra o SIDA (PNLS) was created to coordinate national prevention efforts and donor-supported activities. The PNLS has been involved in gathering data and developing the National Response, and since mid-1997 has been working on a multisectoral approach to development of a National Strategic Plan.

U.S. Agency for International Development
Population, Health and Nutrition Programs
HIV/AIDS Division
1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

Impact
Implementing AIDS Prevention and Care (IMPACT) Project
Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516-9779
Fax: (703) 516-9781
URL: www.fhi.org

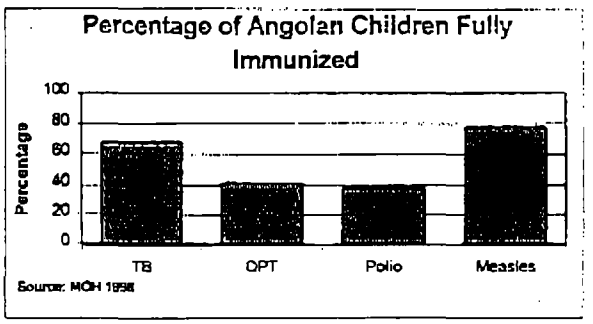
ANGOLA AND HIV/AIDS

Country Profile

Angola is currently in the throes of a complex and delicate transition from war to peace. It is a country rich in natural resources but suffering extreme poverty as a result of the civil war. Twice the size of Texas, Angola has 18 provinces, eight of which are heavily affected by the war. It is estimated that half the population (12 million inhabitants) are living in urban areas and 20 percent in the capital. Angola's external debt is now estimated to be more than $12.5 billion, more than three times its gross domestic product (GDP). The second largest U.S. investment (over $4 billion) and third-largest U.S. trade partner site in sub-Saharan Africa, Angola also provides the United States with nearly 7 percent of its petroleum purchase, and this level is expected to increase to 15 percent within ten years.

Angola's future has been tethered to a tentative peace plan. In late 1998 the peace process broke down and military conflict resumed in eight provinces, resulting in over 600,000 new internally-displaced persons. Virtually all non-security related organizations function poorly, and the health, education, and judicial systems are the most striking institutional casualties. Almost all Angolan regions face shortages of health infrastructure, medicines and medical staff, and potable water—roughly 70 percent of the population still lack access to safe water. In 1996 only 4 percent of the GDP was spent on health.

Approximately 50,000 children have been orphaned as a result of the war (6,000 to 14,000 of those living in the streets). The mortality rate for children under age 5 is more than 290 per 100,000, and 35 percent of all children suffer from malnutrition. In recent years the number of vaccinations given for various diseases has significantly dropped among children. Angola has a high fertility rate (7.2) and low life expectancy rate (47 years). Only 15 percent of births are attended by trained health personnel. The 1996 maternal mortality rate of 1854 per 100,000 is among the highest in the African continent. Tuberculosis (TB) is widespread throughout Angola. According to a 1996 health report, one-third of Angolans carry Koch Bacilli, which causes TB, yet the country does not have a systematic TB prevention system. Of the 15,000 people diagnosed with TB each year, at least half are also carriers of HIV/AIDS.



HIV/AIDS in Angola

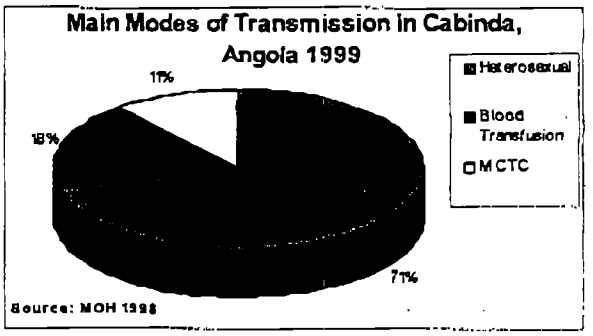
The first case of AIDS was reported in Angola in 1985. The country's HIV prevalence rate is lower than the rates of neighboring Zambia, Namibia, Zimbabwe, and Congo, largely because of the isolating effects of the civil war and under-reporting due to limited clinical and laboratory capacity for diagnosis. Nevertheless, Angola, along with Namibia and South Africa, was one of the only African countries to have experienced proportional increase in HIV prevalence rates of over 100 percent between 1994 and 1997. In Zambia, the proportional increase was less than 10 percent.

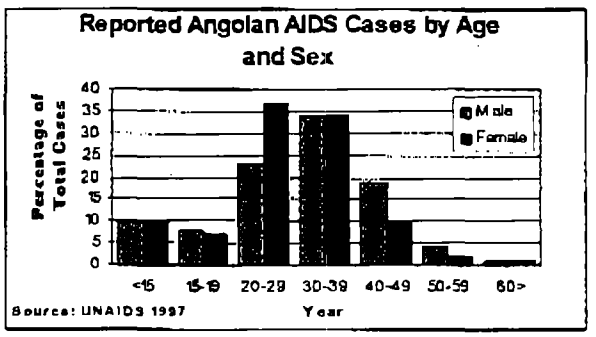
- In 1998 an estimated 4 percent of the general population was HIV-positive.
- An estimated 200,000 Angolans are living with HIV—26,200 of them with AIDS.
- The highest HIV-prevalence groups are females 20 to 39 years old and males 20 to 49 years old.

ANGOLA AND HIV/AIDS

- More than 31,000 people have died from AIDS-related diseases since the beginning of the epidemic in Angola—8,000 of them in 1998.
- In 1998, 15 percent of military personnel were HIV-positive.
- Only 6.7 percent of AIDS cases, where it was possible to collect information, had used condoms during occasional sexual intercourse, or with his sexual partner.

According to the Joint United Nations Programme for HIV/AIDS (UNAIDS), the main mode of HIV transmission in Angola is through multiple-partner heterosexual sexual activity (41 percent). Several factors contribute to the spread of HIV in Angola, including movement of soldiers throughout the country, massive rural-urban migration, increasing numbers of internally displaced people and refugees, increasing numbers of sex workers, high incidence of sexually transmitted infections (STIs), limited access to health/STI clinics due to destruction of main health infrastructures, high incidence of HIV/AIDS in neighboring countries, and low rates of condom availability and use.





Women and HIV/AIDS

The number of women living with HIV/AIDS is growing. Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound their vulnerability.

- In 1998, 8 percent of pregnant women in Cabinda tested positive for HIV and 3.3 percent in Zaire province in 1992.
- According to two studies in Luanda, STIs in pregnant women are very prevalent—1 in 3 for candidiasis, 1 in 11 for gonorrhea, 1 in 4 for chlamydia and 1 in 8 for genital ulcers. An estimated 20 percent of the Angolan population live in Luanda.
- Equal numbers of men and women are infected with HIV.
- The adult literacy rate for women is approximately 29 percent, making it very difficult to implement traditional HIV prevention projects.

Children, Youth and HIV/AIDS

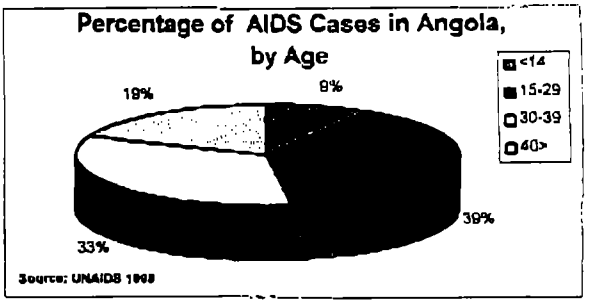
Forty-eight percent of the population is under age 15. The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV.

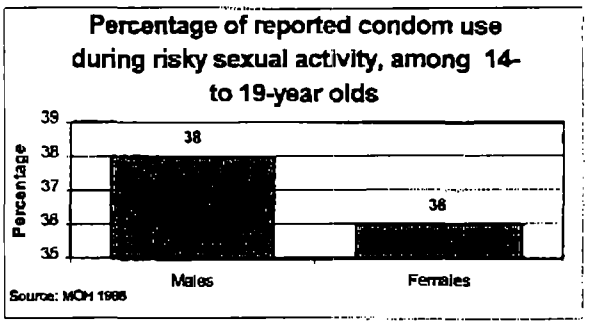
- More than 5,200 children under age 15 are living with HIV/AIDS.
- Six percent of AIDS cases are children under age 5.
- Mother-to-child transmission (MTCT) accounts for 11 percent of all HIV/AIDS cases.
- Approximately 8 percent of all AIDS cases are under age 14.
- To date, an estimated 19,000 children have been orphaned by HIV/AIDS.

- Seventeen percent of all HIV-positive individuals were infected through blood transfusions—80 percent of these transfusions were performed in children under age 14.
- There has been an increase in the number of 8- to 10-year-old sex workers.

Youth and young adults account for a large percentage of all HIV/AIDS cases in Angola.

- More than 35 percent of all reported AIDS cases are 15 to 29 years old.
- A greater percentage of females than males in the 15- to 29-year-old age group have AIDS.
- Despite high rates of HIV risk behavior and infection among young people, only 38 percent of males and 36 percent of females 14 to 19 years old report using a condom during risky sexual activity.





Socioeconomic Effects of AIDS

About 90 percent of reported AIDS cases are 20 to 49 years old. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this implies switching from export crops to food crops—thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. And AIDS adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children and 10- to 12-year-olds become heads of households.

(For country-specific information on the socioeconomic impact of HIV/AIDS refer to the *socioeconomic analysis* presented by the Policy Project.)

Interventions

Despite all the social, political and economic problems in the country, several HIV/AIDS prevention and mitigation activities have been carried out by the government, NGOs, churches, foundations and communities.

National Response

In 1987 the Programa Nacional de Luta contra o SIDA (PNLS) was created to coordinate national prevention efforts and donor-supported activities. The PNLS has a central administrative body located in the Ministry of Health. Since its conception the PNLS has been involved in gathering data and developing the National Response. Currently, funding for all STI/HIV/AIDS interventions, with the exception of salaries for nationals, comes entirely from external sources.

Some of the major areas of focus in 1998 included:

- Advocacy for an expanded response
- Development of a National Strategic Plan
- Support to NGOs for specific projects
- Epidemiological surveillance
- Information, education and communication campaigns
- Training
- Blood safety

In 1999 the PNLS is planning to implement studies related to the socio-cultural aspects of HIV/AIDS in Angola, socioeconomic impact on HIV/AIDS and the workplace, and an HIV/AIDS policy and needs assessment.

Some of the 1999 priority intervention areas identified by the PNLS and UNAIDS include:

- Advocacy: Involvement of other ministries, Parliament, ranking political and church leaders in the creation of a multisectoral approach to HIV/AIDS prevention in Angola.
- Health education: Targeted interventions for high-risk groups such as sex workers, the military, and prisoners, and increased HIV/AIDS prevention programs in schools
- Social marketing of condoms/availability of condoms
- Prevention and control of STIs
- Safety of blood supplies: Integration of mobile labs for screening blood products, particularly at the provincial level
- Provision of logistical support to NGOs and religious institutions
- Epidemiological surveillance: Increased surveillance for HIV, syphilis and HBV in selected provinces among donors, STI and TB patients
- Civil-military alliance: Enhance the role of the military in the institution of HIV prevention programs

Since mid-1997 the PNLS has been working with nine other ministries, NGOs, churches, and community-based organizations (CBOs) on a multisectoral approach to development of a National Strategic Plan: Its completion and implementation are PNLS priorities in 1999. Following workshops held with PNLS leadership, other ministries, representatives from private industry, churches and national NGOs, it is expected that a first draft will be completed in July 1999. The PNLS is also making efforts to involve the international community in supporting activities related to HIV/AIDS prevention, care, counseling, and training.

Donors

Multilateral and bilateral donors are actively engaged in HIV/AIDS activities in Angola. According to a UNAIDS/Harvard study, each bilateral and international organization contributed the following in 1996-1999 (some numbers are still not available for 1998-1999):

Organization	Amount US$ 1996-97	Amount US$ 1998-99
EU	3,737,398	N/A
SIDA	520,020	N/A
Swedish Embassy	N/A	150,000
Belgium Government	117,000	320,507
Norwegian Embassy	N/A	14,500
INTERMOM	13,040	N/A
Development Workshop	12,500	N/A
MAP International	8,000	N/A
Nestle	1,200	8,000
ACORD	700	N/A
Total	**4,409,858**	**493,007**

Bilateral organizations' contributions 1996-1999

USAID is currently working under a strategy approved in 1995. The operating environment of Angola and the Central Africa region has changed dramatically in the last few years, reflecting the U.S. State Department's decision to "deepen and broaden" the U.S. relationship with Angola, especially targeting three areas of cooperation: humanitarian assistance, democracy and governance.

USAID/Angola did not receive HIV/AIDS funding for FY 1998. However, the mission is currently developing a new strategy that will strengthen child survival and other health-related activities. In 1999 USAID will:

- Assist war-affected Angolans through support for resettlement, reconstruction, and local self-reliance.
- Increase employment and other economic opportunities in rural areas.
- Help build a more open society and responsive political institution.

Also, because virtually all Angolan regions face shortages of potable water, health infrastructure, medicines and medical staff, USAID and other donors are working to address these constraints.

UNAIDS has had a coordinating Theme Group based in Angola, since 1996. It includes representatives from UNDP, UNICEF, UNESCO, WHO, World Bank, UNFPA, UNHCR, MONUA (UN peace keeping forces), FAO, WFP, and the National AIDS Control Programme, and chaired by WHO. Support from the UNAIDS cosponsors and other agencies in 1996-1999 included the following (some of the numbers are not available):

Organization	Amount US$ 1996-97	Amount US$ 1998-99
WHO	5,000	50,000
UNDP	N/A	N/A
UNFPA	729,000 (including reproductive health activities)	1,654,000 (including reproductive health activities)
UNESCO	N/A	8,000
UNICEF	300,000	25,000
World Bank	56,077	230,632
UNAIDS	165,000	550,000
Total	**1,255,077**	**2,517,632**

UNAIDS cosponsor support 1996-1999

According to UNAIDS, the Theme Group has been most successful in the areas of promotion of policy decisions, joint programming with the national authorities, advocacy issues, and technical coordination and resource mobilization within the UN system.

UNAIDS is assisting the NACP in developing a National Strategic Plan and implementing several varied activities. It is also discussing the need to formulate a joint/integrated UN Plan on HIV/AIDS for 1999 to the year 2000. In April 1999, as part of the International Partnership Initiative Against HIV/AIDS in Angola, UNAIDS in collaboration with the Swedish Embassy sponsored a meeting on Advocacy and HIV in Luanda. This meeting was attended by more than a dozen foreign ambassadors and the Angolan ministers of Foreign Affairs and Health.

UNAIDS also coordinates a Technical Working Group, chaired by the UNFPA, which is currently reviewing the technical components of proposals submitted by national NGOs. These projects will be funded by the Swedish government through an agreement with UNAIDS. A portion of these funds ($150,000) was made available in 1999 to national NGOs to implement a variety of activities.

The World Bank supports HIV/AIDS prevention efforts through a $19.9 million *First Health* project; $0.9 million of this funding is dedicated specifically to HIV/AIDS activities. The project objectives are to strengthen the Ministry of Health's capabilities in essential areas of health policy, health sector management, and public health program development, and to improve health care in selected regions through the rehabilitation of training and health facilities.

The Swedish Embassy has supported several activities including a January 1998 workshop focusing on coordination strategies between the PNLS, NGOs, churches, and foundations. Recently, joint strategies were agreed upon between the Swedish Embassy and the UN Theme Group for future financial support of interventions to be developed by NGOs, churches and foundations. For 1999 the Swedish Embassy has allocated $150,000 for HIV/AIDS activities.

Private Voluntary Organizations (PVOs), Nongovernmental Organizations (NGOs) and Research Institutions

A number of PVOs implement activities funded by multilateral, bilateral, and private donors. NGOs also receive funding from a variety of sources. Some of the major PVOs include Population Services International, CARE, Save the Children, and Catholic Relief Services. *See attached preliminary chart for PVO, USAID cooperating agencies, and NGO target areas of HIV/AIDS activities. This list is evolving and changes periodically.*

NGOs and religious institutions are currently active in the areas of mitigation, care and counseling of people living with HIV/AIDS (PLWHA) and their families. Churches have also been involved in medical assistance programs. Although these institutions have been providing the bulk of services, according to UNAIDS and the NACP they need logistical support and training, particularly in administration.

Challenges

Major constraints to HIV/AIDS control in Angola include:

- The ongoing civil strife, which makes it difficult to make HIV/AIDS a priority.
- Due to the civil war, funds from donors have been frozen and some international donors and NGOs have exited from areas in need of humanitarian relief and HIV prevention activities.
- Lack of reliable information and unstable socioeconomic conditions impede the collection of reliable, timely, and complete HIV/AIDS data.
- Government bureaucracy and weak post-civil war infrastructure.

- A low literacy rate, which makes it more difficult to mount effective education campaigns.
- Lack of government leadership and empowerment of communities in responding to the epidemic.
- Limited coordination of the PNLS, NGO, and international donor activities at central and provincial levels.
- Shortages of potable water, health infrastructure, medicines and medical staff due to the civil war.
- Failure of health centers to educate the population about HIV/AIDS.
- High turnover of decision makers and AIDS program managers within the national institutions.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Angola:

- A multisectoral government agency with financial resources and direct presidential or national committee support to lead and coordinate the response to the epidemic.
- Long-term rehabilitation programs which address the lack of access to health care, sanitation, and nutrition.
- Effective surveillance and reporting systems.
- Implementation of programs that train and value PLWHA and reduce discrimination in the larger community.
- Integration of STI/HIV/AIDS management into existing public health centers.
- Cost-effective condom social marketing programs that include information, education and communication (IEC) and general health education components.
- Community-based programs to provide follow-up and continuance of care for PLWHA.

The Future

The civil war has devastated Angola's infrastructure and severely weakened the country's ability to respond effectively to the HIV/AIDS epidemic, which threatens to further erode the country's stability and development. The Angolan government, in collaboration with UNAIDS, has initiated a multisectoral, comprehensive response to slow the spread of the rapidly growing HIV/AIDS epidemic. However, Angola's political leaders must act now to ensure that this plan will be carried out.

Important Links

1. The National AIDS Control Program:
2. UNAIDS Country Program Advisor: Rui Gama Vaz, UNAIDS, c/o President Groupe Thematique des Nations Unies, sur le VIH/SIDA, OMS, CP 3243 Luanda; Tel: (244) 2 33 23 98; Fax: (244) 33 23 14; e-mail: sida@ebonet.net
3. USAID: Filomena Maxwell,

U.S. Agency for International Development
Population, Health and Nutrition Programs
HIV/AIDS Division
1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

Impact
Implementing AIDS Prevention and Care (IMPACT) Project
Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516 9779
Fax: (703) 516 9781
URL: www.fhi.org

June 1999

HIV/AIDS Profile: Angola

Demographic Indicators

Population (1,000s)	10,145	Growth Rate (%)	2.2
Infant Mortality Rate (per 1,000)		Life Expectancy	
Both Sexes	196	Both Sexes	38
Male	208	Male	37
Female	183	Female	40
Crude Birth Rate (per 1,000)	47	Crude Death Rate (per 1,000)	25
Percent Urban	32	Total Fertility Rate	6.5

Note: Above indicators are for 2000.

Estimated % of adults living with HIV/AIDS, end 1999	2.8 %
Cumulative AIDS rate (per 1,000) as of 8/31/97	0.20
Cumulative AIDS cases as of 8/31/97	1926

Sources: U.S. Census Bureau, Population Reference Bureau, UNAIDS, World Health Organization

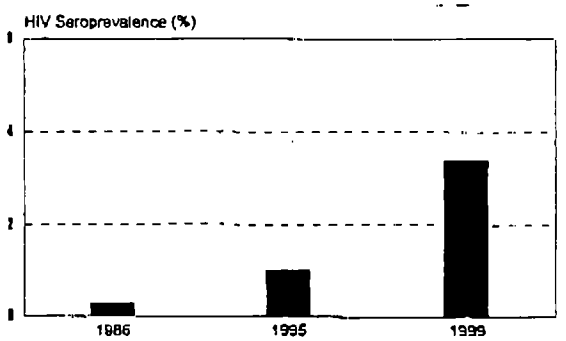
Epidemiological Data

Epidemic State: Generalized

Political and civil unrest have characterized Angola for the past several years. As a result, there is little information available on the HIV epidemic there. Data from the early 1990s indicated a rising level of infection among pregnant women in Luanda.

- HIV seroprevalence among pregnant women in Luanda, the capital, has increased since 1986. In 1986, less than 1 percent of pregnant women were infected; in 1999, 3 percent of pregnant women tested were HIV positive.

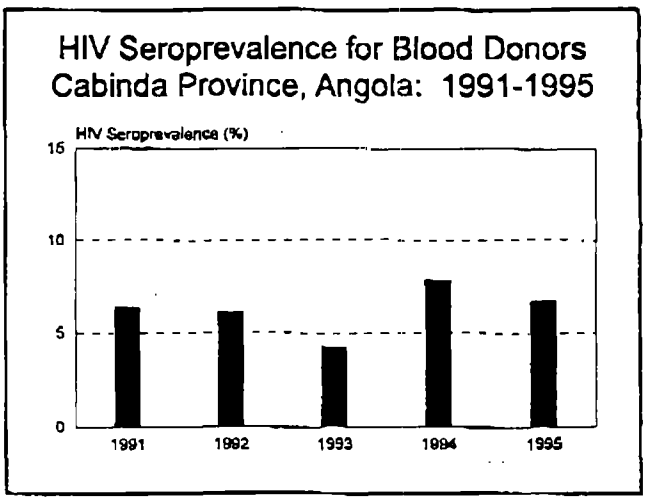
HIV Seroprevalence for Pregnant Women
Luanda, Angola: 1986-1999



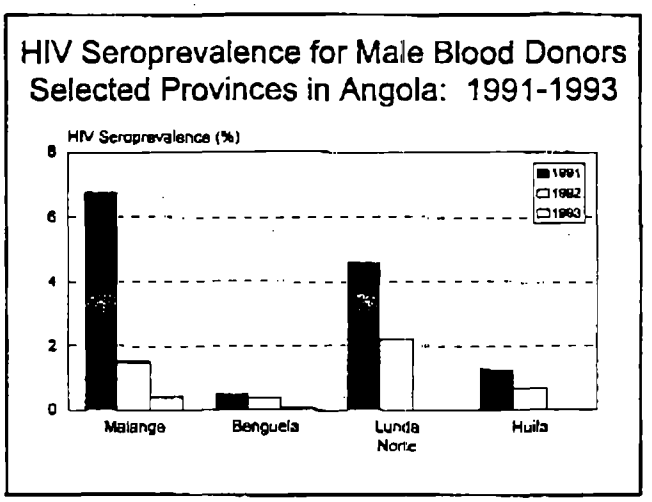
Source: International Programs Center, Population Division, U.S. Census Bureau, HIV/AIDS Surveillance Data Base, June 2000.

Angola

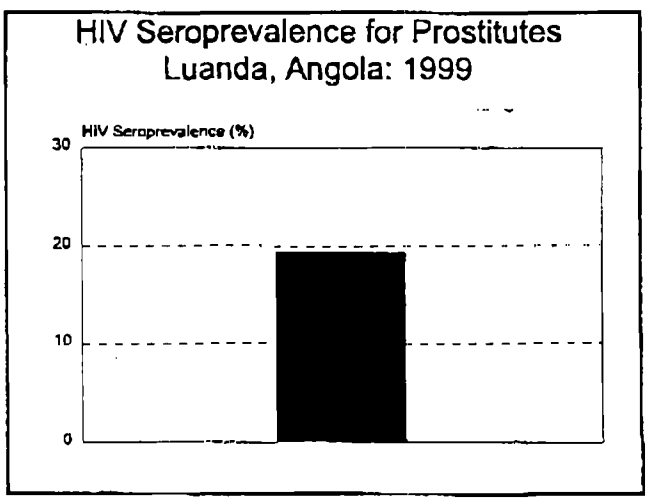
- In Cabinda Province, HIV prevalence among blood donors has fluctuated around 6 percent. In 1991, 6 percent of donors were infected. In 1995, 7 percent were HIV positive.



- Infection levels have declined in provinces where blood donor data are available. Seven percent of male blood donors in Malange Province were infected in 1991. Two years later, that level had declined to less than 1 percent. Rates in Benguela Province were low during the time period, ranging from 0.1 to 0.5 percent. No recent information is available.



- Nineteen percent of prostitutes tested in Luanda were HIV positive in 1999.



Source: International Programs Center, Population Division, U.S. Census Bureau, HIV/AIDS Surveillance Data Base, June 2000.

Sources for Angola

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M0457 Moussi, E., 1993, Actualisation of AIDS Cases Notification and Data on Epidemiological Surveillance Studies, World Health Organization.

U0057 U. S. Department of State, 2000, AIDS Info from Angola for UN/Africa, Unclassified cable, January, Luanda 000064.

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FAX TRANSMISSION

Agency for International Development
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Subject: Background Information on HIV/AIDS

Date: 10/11/00 No. of Pages: 26

Message: For the BCC Meeting on Angola.

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1st part - 12 pages
2nd part - 14 pages

Angola

Epidemiological Fact Sheet

onHIV/AIDS
andsexually
transmitted
infections

2000Update

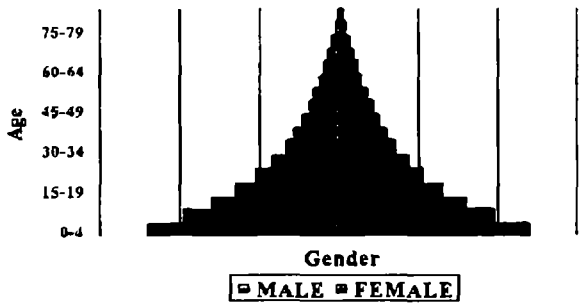
UNAIDS

WorldHealth
Organization

2–Angola

CountryInformation

Populationpyramid,1999



Indicators	Year	Estimate	Source
TotalPopulation(thousands)	1999	12,479	UNPOP
PopulationAged15-49(thousands)	1999	5,367	UNPOP
AnnualPopulationGrowth	1990-1998	3.4	UNPOP
%ofPopulationUrbanized	1998	31	UNPOP
AverageAnnualGrowthRateofUrbanPopulation	1990-1998	4.8	UNPOP
GNPPerCapita(US$)	1997	260	WorldBank
GNPPerCapitaAverageAnnualGrowthRate	1996-1997	-2.5	WorldBank
HumanDevelopmentIndexRank(HDI)	1999	160	UNDP
%PopulationEconomicActive	1997	45.0	UNDP
UnemploymentRate	1997	32.1	INE
TotalAdultLiteracyRate	1997	43	INE
AdultMaleLiteracyRate	1997	56	INE
AdultFemaleLiteracyRate	1995	28	INE
MaleSecondarySchool EnrollmentRatio	1996	14.2	UNESCO
FemaleSecondarySchool EnrollmentRatio	1996	9.4	UNESCO
CrudeBirthRate(birthsper1,000pop.)	1999	48	UNPOP
CrudeDeathRate(deathsper1,000pop.)	1999	18	UNPOP
MaternalMortalityRate(per100,000livebirths)	1990	1,854	MOH
LifeExpectancyatBirth	1998	47	UNPOP
TotalFertilityRate	1998	6.7	UNPOP
InfantMortalityRate(per1,000livebirths)	1999	123	UNICEF/UNPOP

UNAIDS/WHOWorkingGrouponGlobalHIV/AIDSandSTI Surveillance

Global Surveillance of HIV/AIDS and sexually transmitted infections (STIs) is a joint effort of WHO and UNAIDS. The UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, initiated in November 1998, guides respective activities. The primary objective of the working group is to strengthen national, regional and global structures and networks for improved monitoring and surveillance of HIV/AIDS and STIs. For this purpose, the working group collaborates closely with national AIDS programmes and a number of national and international experts and institutions. The goal of this collaboration is to compile the best information available and to improve the quality of data needed for informed decision-making and planning at national, regional and global levels. The Epidemiological Fact Sheets are one of the products of this close and fruitful collaboration across the globe.

The working group and its partners have established a framework standardizing the collection of data deemed important and for a thorough understanding of the current status and trends of the epidemic, as well as patterns of risk and vulnerability in the population. Within this framework, the Fact Sheets collate the most recent country-specific data on HIV/AIDS prevalence and incidence, together with information on behaviours (e.g. casual sex and condom use) which can spur or stem the transmission of HIV.

Not unexpectedly, information on all of the agreed-upon indicators was not available for many countries in 1999. However, these updated Fact Sheets do contain a wealth of information which allows identification of strengths in currently existing programmes and comparisons between countries and regions. The Fact Sheets may also be instrumental in identifying potential partners when planning and implementing improved surveillance systems.

The fact sheets can be only as good as information made available to the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance. Therefore, the working group would like to encourage all programme managers as well as national and international experts to communicate additional information to the working group whenever such information becomes available. The working group also welcomes any suggestions for additional indicators or information proven to be useful in national or international decision-making and planning.

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http://www.who.ch/emc/diseases/hiv
http://www.unaids.org

Estimated number of people living with HIV/AIDS

In 1999 and during the first quarter of 2000, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates on people living with HIV/AIDS. These calculations are based on the previously published estimates for 1997 and recent trends in HIV/AIDS surveillance in various populations. A methodology developed in collaboration with an international group of experts was used to calculate the new estimates on prevalence and incidence of HIV and AIDS deaths, as well as the number of children infected through mother-to-child transmission of HIV. Different approaches were used to estimate HIV prevalence in countries with low-level, concentrated or generalized epidemics. The current estimates do not claim to be an exact count of infections. Rather, they use a methodology that has thus far proved accurate in producing estimates that give a good indication of the magnitude of the epidemic in individual countries. However, these estimates are constantly being revised as countries improve their surveillance systems and collect more information.

Adults in this report are defined as women and men aged 15 to 49. This age range covers people in their most sexually active years. While the risk of HIV infection obviously continues beyond the age of 50, the vast majority of those who engage in substantial risk behaviours are likely to be infected by this age. The 15 to 49 age range was used as the denominator in calculating adult HIV prevalence.

❑ Estimated number of adults and children living with HIV/AIDS, end of 1999

These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 1999:

Adults and children	**160000**		
Adults (15-49)	**150000**	**Adult rate (%)**	**2.78**
Women (15-49)	**82000**		
Children (0-14)	**7900**		

❑ Estimated number of deaths due to AIDS

Estimated number of adults and children who died of AIDS during 1999:

Deaths in 1999	**15000**

❑ Estimated number of orphans

Estimated number of children who have lost their mother or both parents to AIDS (while they were under the age of 15) since the beginning of the epidemic:

Cumulative orphans	**98000**

Estimated number of children who have lost their mother or both parents to AIDS and who were alive and under age 15 at the end of 1999:

Current living orphans	**62519**

Assessment of epidemiological situation – Angola

Limited HIV seroprevalence information among antenatal clinic attendees is available since the mid-1980s from Angola. In Luanda, the major urban area, HIV prevalence among antenatal women tested increased from 0.3 percent in 1986 to 1 percent in 1995. Outside of the major urban areas, 7 percent of antenatal women tested in Cabinda Province in 1992 tested positive for HIV-1 and/or HIV-2 [HIV prevalence by type is not available.] Between 1993 and 1996, HIV-1 prevalence increased from 7 to 9 percent of antenatal clinic attendees tested. In 1995, 0.5 percent of antenatal women tested in Namibe Province were HIV-1 positive.

There is no information available on HIV prevalence among sex workers.

In 1987-88, 13 percent of male STD clinic patients tested in Dundo were HIV positive. In 1992, 3 percent of female STD clinic patients tested in Luanda were HIV positive.

In 1995, 1 percent of military personnel tested in Luanda were HIV positive.

4-Angola

HIV sentinel surveillance

This section contains information about HIV prevalence in different populations. The data reported in the tables below are mainly based on the HIV database maintained by the United States Bureau of the Census where data from different sources, including national reports, scientific publications and international conferences is compiled. To provide for a simple overview of the current situation and trends over time, summary data are given by population group, geographical area (Major Urban Areas versus Outside Major Urban Areas), and year of survey. Studies conducted in the same year are aggregated and the median prevalence rates (in percentages) are given for each of the categories. The maximum and minimum prevalence rates observed, as well as the total number of surveys/sentinel sites, are provided with the median, to give an overview of the diversity of HIV-prevalence results in a given population within the country. Data by sentinel site or specific study on which the medians were calculated are printed at the end of this fact sheet.

The differentiation between the two geographical areas Major Urban Areas and Outside Major Urban Areas is not based on strict criteria, such as the number of inhabitants. For most countries, Major Urban Areas were considered to be the capital city and – where applicable – other metropolitan areas with similar socio-economic patterns. The term Outside Major Urban Areas considers that most sentinel sites are not located in strictly rural areas, even if they are located in somewhat rural districts.

❑ **HIV prevalence in selected populations in percent** (for blood donors: 1/100000)

Group	Area		1985	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Pregnant women	Major Urban Areas	N-sites			1				1			1				
		Minimum			0.3				0.7			1.2				
		Median			0.3				0.7			1.2				
		Maximum			0.3				0.7			1.2				
Pregnant women	Outside Major Urban Areas	N-sites							1	1	1	2	1			
		Minimum							6.6	7.19	7.2	0.5	8.5			
		Median							6.6	7.19	7.2	3	8.5			
		Maximum							6.6	7.19	7.2	5.5	8.5			

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Sex workers	Major Urban Areas	N-sites																
		Minimum																
		Median																
		Maximum																
Sex workers	Outside Major Urban Areas	N-sites																
		Minimum																
		Median																
		Maximum																

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Injecting drug users	Major Urban Areas	N-sites																
		Minimum																
		Median																
		Maximum																
Injecting drug users	Outside Major Urban Areas	N-sites																
		Minimum																
		Median																
		Maximum																

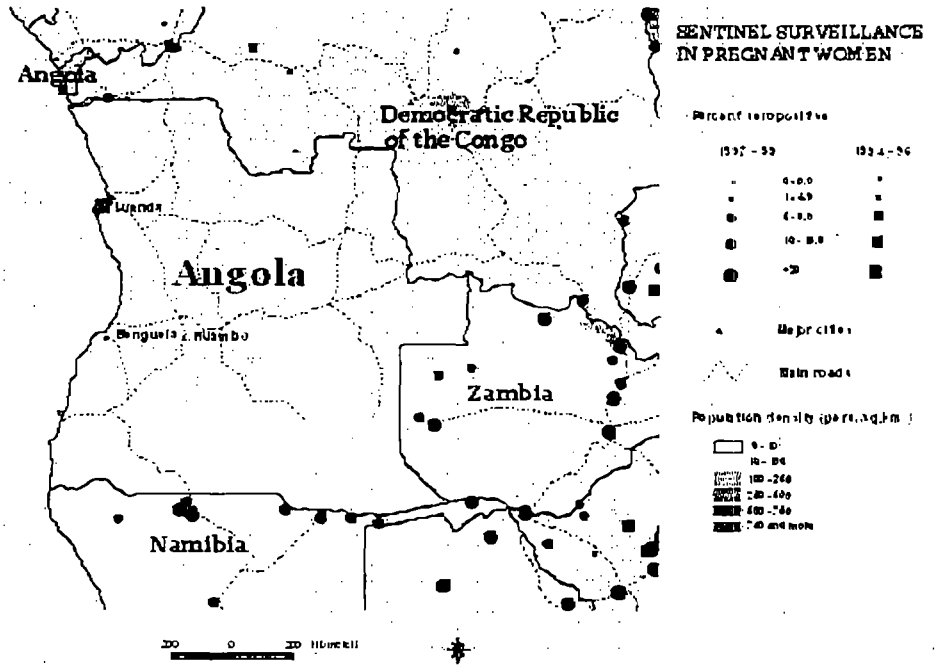
Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
STI patients	Major Urban Areas	N-sites									1							
		Minimum									2.5							
		Median									2.5							
		Maximum									2.5							
STI patients	Outside Major Urban Areas	N-sites					1											
		Minimum					12.7											
		Median					12.7											
		Maximum					12.7											

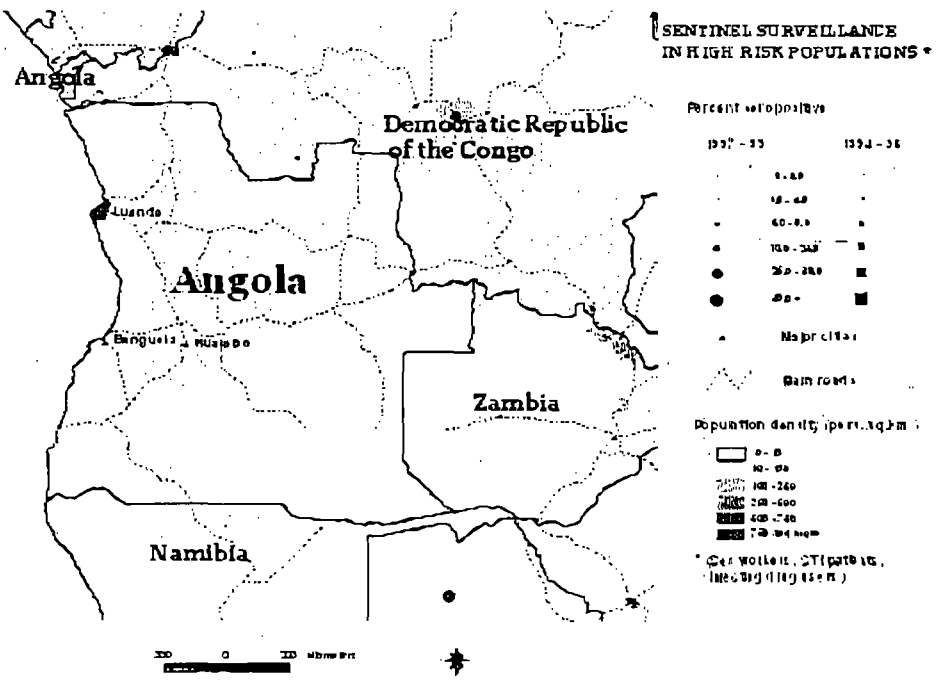
Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Blood Donors	National	N-sites																
		Minimum																
		Median																
		Maximum																
Blood Donors	Major Urban Areas	N-sites																
		Minimum																
		Median																
		Maximum																

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Men having sex with men	Major Urban Areas	N-sites																
		Minimum																
		Median																
		Maximum																

Maps of HIV sentinel sites

Mapping the geographical distribution of HIV sentinel sites for different population groups may assist interpreting both the national coverage of the HIV surveillance system and explaining differences in levels and trends of prevalence. The UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, in collaboration with the UNICEF/WHO Health Map Programme, has produced maps showing the location and HIV prevalence of HIV sentinel sites in relation to population density, major urban areas and communication routes. Maps illustrate separately the most recent results from HIV sentinel surveillance in pregnant women and in sub-populations at higher risk of HIV infection.





6-Angola

ReportedAIDScases

AIDScasesbyyearofreporting

1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	Total	Unkn
0	0	0	0	0	0	4	8	34	74	78	93	130	147	135	157	321	329	416	507		2433	

Dateoflastreport:26/Mar/99

Following WHO and UNAIDS recommendations, AIDS case reporting is carried out in most countries. Data from individual AIDS cases is aggregated at the national level and sent to WHO. However, case reports come from surveillance systems of varying quality. Reporting rates vary substantially from country to country and low reporting rates are common in developing countries due to weaknesses in the health care and epidemiological systems. In addition, countries use different AIDS case definitions. A main disadvantage of AIDS case reporting is that it only provides information on transmission patterns and levels of infection approximately 5-10 years in the past, limitingitsusefulnessformonitoringrecentHIVinfections.

Despite these caveats, AIDS case reporting remains an important advocacy tool and is useful in estimating the burden of HIV-related morbidity as well as for short-term planning of health care services. AIDS case reports also provide information on the demographic and geographic characteristics of the affected population and on the relative importance of the various exposure risks. In some situations, AIDS reports can be used to estimate earlier HIV infection patterns using back-calculation. AIDS case reports and AIDS deaths have been dramatically reduced in industrialized countries with theintroductionofHAART(HighlyActiveAnti-RetroviralTherapy).

AIDS cases by mode of transmission

Hetero:Heterosexualcontacts.
HomoBi:Homosexualcontactsbetweenmen.
IDU:Injectingdruguse.Thistransmissioncategoryalsoincludes casesinwhichotherhigh-riskbehaviourswerereported,inaddition toinjectionofdrugs.
Blood:Bloodandbloodproducts.
Perinatal:Verticaltransmissionduringpregnancy,birthor breastfeeding.
NS:Notspecified/unknown.

Sex	Trans. Group	<96	1996	1997	1998	1999	Unkn	Total	%
All	Total								
	Hetero								
	HomoBi								
	IDU								
	Blood								
	Perinatal								
	OtherKnown								
	Unknown								
Male	Total								
	Hetero								
	HomoBi								
	IDU								
	Blood								
	Perinatal								
	OtherKnown								
	Unknown								
Female	Total								
	Hetero								
	IDU								
	Blood								
	Perinatal								
	OtherKnown								
	Unknown								
NS	Total								
	Hetero								
	IDU								
	Blood								
	Perinatal								
	OtherKnown								
	Unknown								

Aids cases by age and sex

Sex	Age	<96	1996	1997	1998	1999	Unkn.	Total	%
All	All							2433	100.0
	0-4							59	2.4
	5-14							56	2.3
	15-19							94	3.9
	20-29							717	29.5
	30-39							827	34.0
	40-49							318	13.1
	50-59							101	4.2
	60+							29	1.2
	NS							232	9.5
Male	All							1110	100.0
	0-4							34	3.1
	5-14							31	2.8
	15-19							37	3.3
	20-29							290	26.1
	30-39							418	37.7
	40-49							208	18.7
	50-59							56	5.0
	60+							16	1.4
	NS							20	1.8
Female	All							1134	100.0
	0-4							25	2.2
	5-14							26	2.2
	15-19							57	5.0
	20-29							427	37.7
	30-39							409	36.1
	40-49							110	9.7
	50-59							45	4.0
	60+							13	1.1
	NS							23	2.0
NS	All							189	100.0
	0-4							0	0.0
	5-14							0	0.0
	15-19							0	0.0
	20-29							0	0.0
	30-39							0	0.0
	40-49							0	0.0
	50-59							0	0.0
	60+							0	0.0
	NS							0	0.0

CurableSexuallyTransmittedInfections(STIs)

Thepredominantmodeoftransmissionofbothand other STIsissexualintercourse.Measuresforpreventingsexualtransmissionof and STIarethesame,asarethetargetaudiencesforinterventions.Inaddition,strongevidencesupportsseveralbiologicalmechanismsthroughwhich STIfacilitate transmissionbyincreasingboth infectiousnessand susceptibility.Significantalsoistheobservationofasharpdeclinein theconcentrationofinthegenitalsecretionswhentheinfectionistreated.Monitoringtrendsin STIcanprovidevaluableinformationonthe sexualtransmissionofaswellastheimpactofbehaviouralinterventions,suchaspromotionofcondomuse.

ClinicalservicesofferingSTIcareareanimportantaccesspointforpeopleathighriskforbothAIDSandSTI,notonlyfordiagnosisandtreatment butalsoforinformationandeducation.Therefore,controlandpreventionofSTIhavebeenrecognizedasamajorstrategyinthepreventionof infectionandultimatelyAIDS.OneofthecornerstonesofSTIcontrolisadequatemanagementofpatientswithsymptomatic STIs.Thisincludes diagnosis,treatmentandindividualhealtheducationandcounsellingondiseasepreventionandpartnernotification.Consequently,monitoringdifferent componentsofSTIcontrolcanalsoprovideinformationon preventionwithinacountry.

☐ **Estimatedincidenceandprevalenceofcurable STIs**

☐

	Incidence				Prevalence			
STI's	Year	Male	Female	All	Year	Male	Female	All
Chlamydia trach.								
Gonorrhoea								
Syphilis								
Trichomonas								

Comments:
Source:

☐ **STIIncidence,men**

PreventionIndicator9:Proportionofmenaged15-49yearswhoreportedepisodesof urethritisinthelast12months.

Year	Area	Age	Rate	N=

Comments:
Sources:

☐ **STIPrevalence,women**

PreventionIndicator8:Proportionofpregnantwomenaged15-24yearsattendingantenatalclinicswhosebloodhasbeen screenedwithpositiveserologyforsyphilis.

Year	Area	Age	Rate	N=

Comments:
Sources:

☐ **STICasemanagement(counselled)**

PreventionIndicator7:ProportionofpeoplepresentingwithSTIorforSTIcareinhealthfacilitieswhoreceivedbasicadviceon condomsandonpartnernotification.

Year	Area	Age	Rate	N=

Comments:
Sources:

☐ **STICasemanagement(treatments)**

PreventionIndicator6:ProportionofpeoplepresentingwithSTIinhealthfacilitiesassessedandtreatedinanappropriateway (accordingtonationalstandards).

Year	Area	Age	Rate	N=

Comments:
Sources:

8–Angola

Healthserviceindicators

HIVpreventionstrategiesdependonthetwineffortsofcareandsupportforthoselivingwithHIVorAIDS,andtargetedpreventionforallpeopleat riskorvulnerabletotheinfection.Theseefforts mayrangefromreachingouttovulnerablecommunitiesthroughlarge-scaleeducationalcampaigns orinterpersonalcommunication;provisionoftreatmentfor STIs;distributionofcondomsandneedles;creatingandenablingenvironmenttoreduce riskybehaviour;providingaccesstovoluntarytestingandcounselling;homeorinstitutionalcareforpersonswithsymptomaticHIVinfection;and preventing perinatal transmissionandtransmissionthroughinfectedneedlesorbloodinhealthcaresettings.Itisdifficulttocapturesuchalarge rangeofactivitieswithoneorjustafewindicators.However,asetofwell-establishedhealthcareIndicators–suchasthepercentageofapopulation withaccesstohealthcareservices;thepercentageofwomencoveredbyantenatalcare;orthepercentageof immunizedchildren–mayhelpto identifygeneralstrengthsandweaknessesofhealthsystems.Specificindicators,suchasaccesstotestingandbloodscreeningforHIV,helpto measurethecapacityofhealthservicestorespondtoHIV/AIDS–relatedissues.

☐ Accesstohealthcare

Indicators	Year	Estimate	Source
%ofpopulationwithaccesstohealthservices–total:			
%ofpopulationwithaccesstohealthservices–urban:			
%ofpopulationwithaccesstohealthservices–rural:			
Contraceptiveprevalencerate(%):	1990-1999	8	UNICEF/UNPOP
%ofbirthsattendedbytrainedhealthpersonnel:	1996	23	MICS/INE
%of1-yr-oldchildrenfully immunized–DPT:	1995-1998	36	UNICEF
%of1-yr-oldchildrenfully immunized–Polio:	1995-1998	36	UNICEF
%of1-yr-oldchildrenfully immunized–Measles:	1995-1998	65	UNICEF
Proportionofblooddonationstested:			
%ofANCclinicswhereHIVtestingisavailable:			
HIV/AIDSHospitalOccupancyRate(Days):			

Male and female condoms are the only technology available that can prevent sexual transmission of HIV and other STIs. Persons exposing themselvestotheriskofsexualtransmissionofHIVshouldhaveconsistentaccesstohighqualitycondoms.AIDSProgrammesimplementactivities toincreasebothavailabilityofandaccesstocondoms.Thetwocondomavailabilityindicatorsbelowareintendedtohighlightareasofstrengthand weaknessatthebeginningandendofthedistributionsystemsothatprogrammaticresourcescanbedirectedappropriatelytoproblemareas.

☐ Condomavailability(centrallevel)

PreventionIndicator2:Availabilityofcondomsinthecountryoverthelast12months(centrallevel).

Year	Area	N	Rate
1992	All	2,000,000	2.9

Comments:
Sources:

☐ Condomavailability(peripherallevel)

PreventionIndicator3:Proportionofpeoplewhocanacquireacondom(peripherallevel).

Year	Area	N	Rate

Comments:
Sources:

Knowledgeandbehaviour

InmostcountriestheHIVepidemicisdrivenbybehaviours(e.g.:multiplesexualpartners,intravenousdruguse)thatexposeindividualstotherisk ofinfection.Informationonknowledgeandonthelevelandintensityofriskbehaviourrelatedto HIV/AIDSisessentialinidentifyingpopulationsmost atriskforHIVinfectionandinbetterunderstandingthedynamicsoftheepidemic.Itisalsocriticalinformationinassessingchangesovertimeas aresultofpreventionefforts.Oneofthemaingoalsofthe2 ndgenerationHIVsurveillancesystemsisthepromotionofregularbehaviouralsurveys inordertomonitortrendsinbehavioursandtargetinterventions.

❑ KnowledgeofHIV-relatedpreventivepractices

PreventionIndicator1:Proportionofpeoplecitingatleasttwoacceptablewaysofprotectionfrom HIVinfection.

Year	Area	AgeGroup	Male	Female	All
1997	All	14-20			93.0
1994	All	15-19			57.6*
1995	All	15-49			82.4
1997	All	15-49			95.0

Comments:
Sources: UNICEF

❑ Reportednon-regularsexualpartnerships

PreventionIndicator4:Proportionofsexuallyactivepeoplehavingatleastonesexpartnerotherthanaregularpartnerinthelast 12months.

Year	Area	AgeGroup	Male	Female
1997	All	15-49	28.4	

Comments:
Sources: Maria Bela Neto.1997:CAP relativas aoHIV/SIDA nos efectivos da força aérea estacionadaemLuanda

❑ Reportedcondomuseinriskscx(gcnpop)

PreventionIndicator5:Proportionofpeoplereportingtheuseofacondomduringthemostrecentintercourseofrisk.

Year	Area	AgeGroup	Male	Female
1997	All	11-25		37.0
1995	All	13-47		27.0*
1997	All	14-19	38.1	36.3
1997	All	31-40	29.0	

Comments:
Sources: Conniott,MS. AgostinhoNetoUniversity,NationalDirectorateofPublicHealth

10–Angola

Knowledgeandbehaviour

❑ Everuseofcondom

Percentageofpeoplewhoeverusedacondom.

Year	Area	AgeGroup	Male	Female	All
1997	All	11-45			15.0*
1995	All	13-47			27.0**
1997	All	14-19	19.0#	9.1	

Comments:

Sources:
*Atillo(1997), Estudo sobre conhecimentos, atitudese praticas da Juventudedo Humabo sobreDTS/SIDAe camisade vénus
**NationalDirectorateofPublicHealth(1995),CAPom relação aoSIDAe uso da camisade vénus
#Conniott,MSetal(1997),CAP relativas gravidezversus aborto provocado nos adolescentes

❑ Medianageatfirstsexualexperience

Medianageofpeopleatwhichtheyfirsthadsexualintercourse.

Year	Area	AgeGroup	Male	Female	All
1997	All	14-20	14.4	15.9	
1996/7	All	14-25			14.7*
1996/8	All	14-25			16.1**

Comments:

Sources:
*Ana Leitao,A Juventudeno quotidiano: conhecimentos, atitudese praticas sobre ensino médio pré-universitariode sete provinciasdo Pais.
** Atillo(1997), Estudo sobre conhecimentos, atitudese praticas da Juventudedo Humabo sobreDTS/SIDAe camisade venus.

❑ Adolescentpregnancy

Percentageofteenagers15-19whoaremothersorpregnantwiththeirfirstchild

Year	Area	AgeGroup	N	Rate
1997	All	14-19		14.3*
1997	All	14-20	456	36.9
1996	All	14-25	2,045	14.7**
1997	All	17-18	129	23.1#

Comments:

Sources:
*Conniott,MSetal(1997),CAP relativas gravidezversus aborto provocado nos adolescentes
**Ana Leitao,A Juventudeno quotidiano: conhecimentos, atitudese praticas sobre ensino médio pre-universitariode sete provinciasdo Pais.
#Ana Leitaoetal(1997), Saude dos adolescentes, comportamentosde riscoemLuanda

MODE = MEMORY TRANSMISSION START=OCT-11 12:25 END=OCT-11 12:51

FILE NO.= 159

NO.	COM	ABBR/NTWK	STATION NAME/ TELEPHONE NO.	PAGES	PRG.NO.	PROGRAM NAME
001	INC	S	94562439	011/015		

********** -202 216-3233 - ***** - 202 216 3233- *********

********** -COMM.JOURNAL- ********** DATE OCT-11-2000 ***** TIME 12:18 *** P.01

MODE = MEMORY TRANSMISSION START=OCT-11 12:08 END=OCT-11 12:18

FILE NO.= 157

NO.	COM	ABBR/NTWK	STATION NAME/ TELEPHONE NO.	PAGES	PRG.NO.	PROGRAM NAME
001	OK	S	94562439	012/012		

********** -202 216-3233 - ***** - 202 216 3233- *********

FAX TRANSMISSION

Agency for International Development
Office of Southern African Affairs

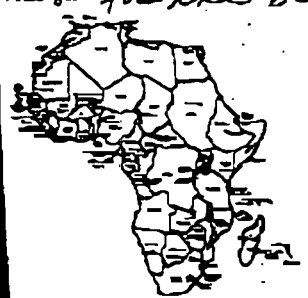
To: Cheryl B
White House AIDS Policy Office

From: Carole Palan
FAX: (202) 216-3233 Phone: 202-712-4790

Subject: Background Information on HIV/AIDS

Date: 10/11/00 No. of Pages: 26

Message: For the BCC Meeting on Angola.



Sent in 2 parts -
1st part - 12 pages
2nd part - 14 pages

Knowledgeandbehaviour

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Sources: Maria Bela Neto,1997;CAP relativos aoHIV/SIDA nos efectivos da força aerea estacionadaemLuanda

❑ Reportedcondomuseinrisksex(genpop)

PreventionIndicator5:Proportionofpeoplereportingtheuseofacondomduringthemostrecentintercourseofrisk.

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1997	All	14-19	38.1	36.3
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10–Angola

Knowledgeandbehaviour

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1997	All	14-19	19.0#	9.1	

Comments:
Sources: *Atilio(1997), Estudo sobre conhecimentos, atitudese praticas da Juventudedo Humabo sobreDTS/SIDAe camisade vénus
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Comments:
Sources: *Ana Letiao,A Juventudeno quotidiano: conhecimentos, atitudese praticas sobre ensino médio pré-universitariode sete provinciasdo País.
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#Ana Letiaoetal(1997), Saude des adolescentes, comportamentosde riscoem Luanda

Sources

Data presented in this Epidemiological Fact Sheet come from several different sources, including global, regional and country reports, published documents and articles, posters and presentations at international conferences, and estimates produced by UNAIDS, WHO and other United Nations Agencies. This section contains a list of the more relevant sources used for the preparation of the Fact Sheet. Where available, it also lists selected national Websites where additional information on HIV/AIDS and STI are presented and regularly updated. However, UNAIDS and WHO do not warrant that the information in these sites is complete and correct and shall not be liable whatsoever for any damages incurred as a result of their use.

Anderson, S., L.F. Dias, L. Cambelela, et al., 1995. HTLV Seroprevalence in Various Population Groups in Angola. IX International Conference on AIDS and STD In Africa, Kampala, Uganda, 12/10-14, Session MoC017.

Angola Programa Nationalde Luta Contra o SIDA, 1998. Situacao Epidemiological do HIV/SIDA em Angola. Ministerio da Sauda, no.2, pp.2-3.

Bottiger, B., I.B. Palme, J.L. DaCosta, et al., 1988, Prevalence of HIV-1 and HIV-2/HTLV-IV Infections in Luanda and Cabinda, Angola, Journal of Acquired Immune Deficiency Syndromes, vol.1, no.1, pp.8-12.

Loukaka, J.C., 1995, Renforcement des Activites de la Surveillance VIH/SIDA/MST, Organisation Mondialede le Sante Bureau Regional OMS, Afrique Representation OMS, Luanda, Angola, octobre, mission report.

Moussi, E., 1993, Actualisation of AIDS Cases Notification and Data on Epidemiological Surveillance Studies, World Health Organization.

Santos-Ferreira, M.O., T. Cohen, M.H. Lourenco, et al., 1990, A Study of Seroprevalence of HIV-1 and HIV-2 in Six Provinces of People's Republic of Angola: Clues to the Spread of HIV..., Journal of Acquired Immune Deficiency Syndromes vol.3, pp.780-786.

Websites: www.aids.africa.com

12–Angola

Annex: HIV Surveillance data by site

Pregnant women	Major Urban Areas	Luanda			0.3						0.7			1.2				
Pregnant women	Outside Major Urban Areas	Cabinda Province									6.8	7.2	7.2	6.6	6.6			
		Namibe Province												0.5				
Sex workers	Major Urban Areas																	
Sex workers	Outside Major Urban Areas																	
Injecting drug users	Major Urban Areas																	
Injecting drug users	Outside Major Urban Areas																	
STI patients	Major Urban Areas	Luanda (Females)									2.6							
STI Patients	Outside Major Urban Areas	Dundo (Males)					12.7											
Blood Donors	National																	
Blood Donors	Major Urban Areas																	
Blood Donors	Outside Major Urban Areas																	

ANGOLA AND HIV/AIDS

Angola's HIV prevalence rate is lower than the rates of neighboring Zambia, Namibia, Zimbabwe and Congo largely because of the isolating effects of the civil war. Nevertheless, Angola, along with Namibia and South Africa, was one of the only African countries to have experienced proportional increase in HIV prevalence rates of over 100 percent between 1994 and 1997.

- in 1998 an estimated 4 percent of the general population was HIV-positive
- an estimated 200,000 Angolans are living with HIV—26,200 of them with AIDS
- the highest HIV-prevalence groups are females 20 to 39 years old and males 20 to 49 years old

More than 31,000 people have died from AIDS-related diseases since the beginning of the epidemic in Angola—8,000 of them in 1998. Approximately 30 to 40 percent of infants born to HIV-infected mothers are expected to be HIV-infected. In 1998 over eight percent of women in Cabinda province tested positive for HIV compared with 3.3 percent who tested positive in Zaire province in 1992. The low adult literacy rate for women makes it difficult to implement traditional HIV prevention programs.

More than 35 percent of all reported AIDS cases are 15 to 19 years old. Approximately 8 percent of all AIDS cases are under age 14. About 90 percent of the reported cases are 20 to 49 years old. Since this age group constitutes the most economically productive segment of the population, an enormous economic burden is created.

The civil war has devastated Angola's infrastructure and severely weakened its ability to respond effectively to the HIV/AIDS epidemic, which threatens to further erode the country's stability and development. In 1987, the National Program for the Fight Against AIDS (PNLS) within the Ministry of Health was introduced to coordinate Angola's national response to HIV/AIDS. All funding comes from external sources and the program coordinates efforts through NGOs and other groups. The PNLS presently has activities in education and awareness, advocacy to involve political and civil leadership,

USAID Program. USAID began its new three-year $3.0 million HIV/AIDS program in September 2000. The program is unique with respect to financing. The U.S.-Angolan Chamber of Commerce has agreed to provide an additional $1.0 million to help procure condoms. The program will initially be located in Luanda. Population Services International (USAID's contractor for this effort) plans to support the Government of Angola's National Strategic Plan and one of its two major objectives (to reduce the transmission of STDs and HIV, particularly among high-risk groups) through the implementation of a condom social marketing activity. The purpose is to promote safe sexual behavior and increase the use of condoms, particularly among commercial sex workers and youth in Luanda where one-fourth or more of the population is residing. In addition to this effort, USAID wants to expand distribution of condoms to at least two other geographic areas and develop workplace AIDS prevention programs.

FAX TRANSMISSION

Agency for International Development
Office of Southern African Affairs

To: Cheryl

From: MELISSA WILLIAMS, AFR/SA
FAX: (202) 216-3233 *Phone:* (202) 712-5811 ☆

Subject: USAID Briefer on HIV/AIDS in Angola

Date: 10/13/00 *No. of Pages:* 3 w/cover.

Message:

ANGOLA AND HIV/AIDS

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