

Civil society response to HIV/ AIDS in Angola

The AIDS epidemic in Angola has been overshadowed by years of destructive civil war that has left Angolan society unprepared to manage the epidemic. In this article **Collette Campher** describes the challenges facing civil society in Angola in building a genuine partnership with government, and in ensuring respect for and promotion of human rights in the various responses.

According to a report by UNAIDS,¹ the HIV/AIDS and STI situation in Angola is precarious and civil conflict and economic decline have severely disrupted health services infrastructures,² making it very difficult to carry out surveillance activities and provide baseline data regarding the HIV/AIDS epidemic in the country. Nonetheless, studies³ conducted in Luanda in population groups that reflect different levels of risk for infection have indicated that the virus is spreading rapidly. The national government is working to institute a National Commission to address the epidemic, which will lead the process of implementation of the national response.

The first case of AIDS in Angola was reported in 1985. Perhaps due to the initially isolating effect of civil war, Angola's HIV prevalence has remained significantly lower than the HIV prevalence in neighbouring Democratic Republic of Congo, Namibia, Zambia, and Zimbabwe. In 2003 and during the first quarter of 2004, UNAIDS and the World Health Organization worked closely with governments and research institutions to recalculate current estimates on people living with HIV/AIDS. These calculations

¹ UNAIDS works through the UN Theme Group on HIV/AIDS, which consist of the UN Country Team (co-sponsors and non-co-sponsors of UNAIDS), with the UNAIDS Country Co-ordinator's office serving as its secretariat (www.unaids.org/nationalresponse/result.asp). Additionally, the Expanded Theme Group serves as a nationwide information-sharing forum on HIV/AIDS attended by the government, bilateral donors, civil society, people living with HIV/AIDS and the UN system. As part of the evolution of the national response to AIDS, this forum is shifting from UN stewardship to a government-led body. There is also a Technical Working Group on HIV/AIDS, chaired by the UNAIDS Country Co-ordinator and comprising UN focal points and the National AIDS Control Programme. Discussions are ongoing about the transformation of this working group into an expanded technical forum including participation of technical focal points from the different sectors. The UN Theme Group is currently engaged in discussions to outline a joint UN workplan to support the implementation of the national strategic plan. Currently, the UN strategy is harmonised with the ongoing elaboration of the UN Development Assistance Framework for Angola, and based on the UN Declaration of Commitment on HIV/AIDS made at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). Since 2001, the Theme Group has supported the following projects through the UNAIDS Programme Acceleration Funds (PAF): a) Inter-provincial training for the decentralised implementation of strategies, b) capacity building for national NGOs, c) Government-led participatory process to draw up the National Strategic Plan on STIs/HIV/AIDS 2003-2008, d) Decentralisation of the National Strategic Plan, e) Sentinel surveillance reinforcement, f) Capacity building of the National AIDS Council to put in place a management and monitoring and evaluation system, g) Support to a programme on the prevention of mother-to-child transmission of HIV, h) International education and communication activities and campaigns. Additional UN joint and collaborative initiatives funded from other sources include: a) Mainstreaming of HIV/AIDS in national institutions to reduce the impact on human development, b) Integration of sexual and HIV/AIDS education in the school curricula, c) Peer education involving youth in HIV/AIDS programmes, d) Reproductive health support programme, surveillance and laboratory capacity building greater involvement of people living with HIV/AIDS.

² UNAIDS National Response Brief.

³ UNAIDS National Strategic Framework 2000-2002.

are based on the previously published estimates for 1999 and 2001 and recent trends in HIV/AIDS surveillance in various population groups. 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 and incidence in countries with low-level, concentrated or generalised epidemics. The current estimates do not claim to be an exact count of infections, but rather 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 15-49, and 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 great majority of those who engage in substantial risk behaviours are likely to be infected by this age. The 15 to 49 range was used as the denominator in calculating adult HIV prevalence, and the estimated number of adults and children living with HIV/AIDS at the end of 2003 was 240 000.⁴ The estimated number of children and adults who died of AIDS during 2003 is 21 000,⁵ while the estimated number of orphans who have lost either one or both parents to AIDS and who were alive and under age 17 at the end of 2003 is 110 000.⁶ Information on HIV seroprevalence in Angola is limited, and there has been little surveillance among women attending antenatal care clinics over the past decade. The latest available antenatal care surveillance data are from 2002, with HIV prevalence in Luanda at 4.6 per cent; with 8 per cent in Malange, 1.4 per cent in Huila, 1.5 per cent in Lunda-Sul, 3.2 per cent in Benguela and 3.3 per cent in Cabinda province. Among 864 sex workers aged 15-45 years HIV prevalence was 32.8 per cent in 2001. Among the 1 000 military personnel tested in Luanda in 2001, HIV prevalence was 3.2 per cent. Given the limited and disparate data available, it is difficult to ascertain recent trends. In Luanda, the major urban area, HIV infection rates among women attending antenatal clinics increased from 0.3 per cent in 1986 to 0.7 per cent in 1992, 3.4 per cent in 1999, and 4.6 per

⁴ Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections 2004 update, jointly published by UNAIDS, WHO and Unicef.

⁵ Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections 2004 update, jointly published by UNAIDS, WHO and Unicef.

⁶ Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections 2004 update, jointly published by UNAIDS, WHO and Unicef.

cent in 2002. HIV prevalence among similar women in Cabinda province ranged from 6 per cent to 8 per cent during 1992-1996 compared to 3.3 per cent in 2002.⁷

As in other parts of sub-Saharan Africa, the main mode of HIV transmission in Angola is sexual activity, particularly multiple-partner heterosexual activity. The sex industry has been particularly affected, fuelled by large-scale displacement to urban areas due to civil strife, and migration due to economic conditions. HIV prevalence among commercial sex workers tested in Luanda increased from 20 per cent in 1999 to 33 per cent in 2001.⁸ Pre-natal transmission also is of concern, with approximately 30 to 40 per cent of Angolan infants born to HIV-positive mothers becoming infected with HIV. Six per cent of AIDS cases occur in children under age 5, and mother-to-child transmission accounts for about 14 per cent of all HIV infections, according to 1999 Ministry of Health estimates.⁹ Without wide-scale access to appropriate prevention of mother-to-child transmission (PMTCT) programmes, high rates of prenatal infection are expected to continue.

A recent survey by UNICEF¹⁰ and the National Institute of Statistics reported only 8 per cent of women as having adequate knowledge of HIV transmission and prevention. Knowledge was lowest in the north and south, but slightly better in the capital, where 20 per cent of women could name three ways of preventing HIV/AIDS.

Several factors fuel the spread of HIV/AIDS in Angola, including movement of troops, rural-urban migration, refugee migration in and out of neighbouring countries, increasing numbers of sex workers, a high incidence of sexually transmitted infections, limited access to health care due to destruction of the health infrastructure, an increasing number of possibly unsafe blood transfusions, and limited condom availability and use.

In April 2002, the government of Angola signed a peace agreement with the National Union for the Total Independence of Angola (UNITA). Subsequently, many parts of the country have become accessible; trade has flourished, and population movements have

⁷ Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections 2004 update, jointly published by UNAIDS, WHO and Unicef.

⁸ Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections 1999-2001, published by UNAIDS.

⁹ Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections 1999-2001, published by UNAIDS.

¹⁰ UNAIDS National Response Brief, at www.unaids.org/nationalresponse/result.asp.

increased. As borders between Angola and its neighbours become more porous, and as members of demobilised military units and refugees return to their homes, HIV transmission is expected to increase dramatically. The resettlement of demobilised soldiers and families continues, as does voluntary repatriation of Angolan refugees from Botswana, Namibia and Zambia.

Angola is slowly emerging from its difficult past, and part of the process for this war-torn country is to initiate and implement national strategies for economic and social development. Health is a major national strategic priority, as the health of the population affects so many other sectors.

Angola has a population of approximately 13.5 million people and one of the highest maternal mortality rates in the world, with 1 850 deaths per 100 000 live births¹¹. The infant mortality rate is an estimated 195 deaths per 1 000 live births. To address the reproductive health needs of the country, *o Plano Estratégico Nacional de Saúde Reprodutiva 2002-2007* (National Plan for Reproductive Health 2002-2007) was adopted in 2002, based on *Prestação de Serviços em Saúde Reprodutiva Políticas e Normas* (Reproductive Health Politics and Norms in Angola). Representatives from the Ministry of Health, the *Direcção Nacional de Saúde Pública* (DNSP) (National Directorate of Public Health), the seventeen provinces, the medical school, international agencies, and non-governmental organisations (NGOs) were called together to develop the strategy collaboratively.

The strategy's objectives and planned activities focus on improving the health of women and men of reproductive age through quality services for prenatal care, birth assistance, family planning, sexually transmitted infections (STIs) and HIV/AIDS. Three major strategies are included in the plan:

1. Develop a strong health monitoring system with concrete process indicators.
2. Implement interventions based on operations research to improve and maintain the quality of family planning/reproductive health (FP/RH) services by strengthening institutional capacity.
3. Utilise social mobilisation techniques with a focus on youth.

¹¹ Ministério da Saúde, Direcção Nacional de Saúde Pública (DNSP). 2002. *Plano Estratégico Nacional de Saúde Reprodutiva 2002-2006*. Luanda, Angola: DNSP.

Prenatal care is not easily available and many women lack access to emergency obstetric services. The utilisation of family planning services is low. Contraceptive prevalence is low, estimated to be 1.8 per cent. All of this data varies geographically between urban and rural areas. Only 8 per cent of Angolan women (aged 15 to 49) have adequate knowledge of HIV/AIDS transmission and prevention, and nearly one-third of all Angolan women have never heard of HIV/AIDS. In 1999, 19 per cent of sex workers in Luanda tested HIV-positive. Two years later, that number had jumped to 32.8 per cent¹².

Health facilities are not in a position to provide HAART as it is largely unobtainable and very expensive. There is only one state hospital in Angola that provides HAART, which is priced at US \$300 per year. HIV/AIDS does not receive much attention as the health department struggles to fight malaria and other diseases. Very few doctors are available to take care of HIV/AIDS patients. The few Voluntary, Counselling and Testing Centres are not well publicised.

The Angolan government does not co-ordinate the health departments' tasks and the department does not appear to receive priority. At present, over 12 000 cases of HIV/AIDS have been registered in Angola, 60 per cent aged between 20 to 39 years and 8.6 per cent of these being pregnant women. Key factors that account for the low utilisation of the existing family planning services include

- Poverty, which is associated with ill health and disease, is omnipresent.
- The current health care delivery system has suffered greatly due to neglect and lack of funding. As a result, the family planning services, where they exist, are inadequate and inefficient.
- Cultural and social factors contribute significantly to misinformation surrounding family planning and barriers to its use.
- Gender inequity in Angola determines that while women have the major responsibility for family care, final decisions regarding the number and spacing of children rest with men.
- The church reinforces cultural norms by preaching against modern contraceptives in a society where having many children is the ideal.

¹² United Nations Office for the Coordination of Humanitarian Affairs (OCHA). 'Angola: Youth Centre to Fight AIDS.' IRINNEWS.org. Accessed 20 August, 2003.

- Youth are especially marginalised because they lack access to information and services.

These are obviously the same factors that increase vulnerability to HIV and AIDS.

During 2003 the Angolan government invited 44 national and international NGOs working in the area of HIV/AIDS to a national workshop as part of a consultative process on various issues regarding HIV/AIDS, and it was agreed to involve NGOs and CBOs at a national level in intervention strategies. While government apparently got off to a good start in seeking to involve NGOs and civil society in the national response, this trend has not continued and government is by and large suspicious of the NGO sector and is apparently reluctant to collaborate with civil society in the national response to HIV/AIDS.

Civil society is thus forced to work independently of government and although many non-governmental organisations are attempting to support the work of government in the national response to HIV/AIDS, government is unsupportive and at times openly hostile towards NGOs, accusing them of politicising the pandemic. The National Commission for the Fight against HIV/AIDS in Angola is currently locked into a debate on the unequal status of civil society organisations, as civil society is not recognised as a collaborating partner by the Angolan government.

The Federation of NGOs in Angola (FONGA) was established in 1991 with a view to ensuring that all NGOs have a voice in the response to HIV/AIDS, and to promote co-operation between Angolan NGOs in their HIV programmes and projects. FONGA's former Secretary General was very outspoken with regard to reporting all human rights violations in Angola during the time of war and was also one of the few who reported such cases. FONGA's current status is that of a national coalition of HIV/AIDS service organisations fighting for the protection of rights for Angolan society generally.

NGOs in Angola find it particularly difficult to conduct human rights and HIV/AIDS work, largely because of limited funds, training materials for trainers, information materials and personnel who have experience in the field of HIV/AIDS and human rights. This is exacerbated by the fact that the national programme to fight against HIV/AIDS includes only government organisations in its plan.

A meeting of PLWHAs, NGOs and CBOs was convened in Angola together with SCARJOV and agreed to conduct training in order to raise awareness of HIV/AIDS issues, and

will include Luanda, Cabinda, Lunda-Sul and Norte, Malange, Uige, Moxico, Zaire, Kuando Kubango and Cunene, as these provinces pose a high risk of infection due to movement of people from adjoining states. ARASA believes that training and advocacy for law reform on HIV/AIDS will reap benefits that can turn the tide where morbidity and mortality rates are impacting on the economies of the SADC states. Such training will emphasise the use of international instruments already in place which emphasise that human rights are for everyone everywhere, that human rights are universal, interrelated and indivisible, and that it is primarily about the relationship between the individual, governments and civil society generally. We call on our SADC heads of states, the private sector and civil society to be more vigilant in their approach in order to ensure the implementation of these human rights instruments.