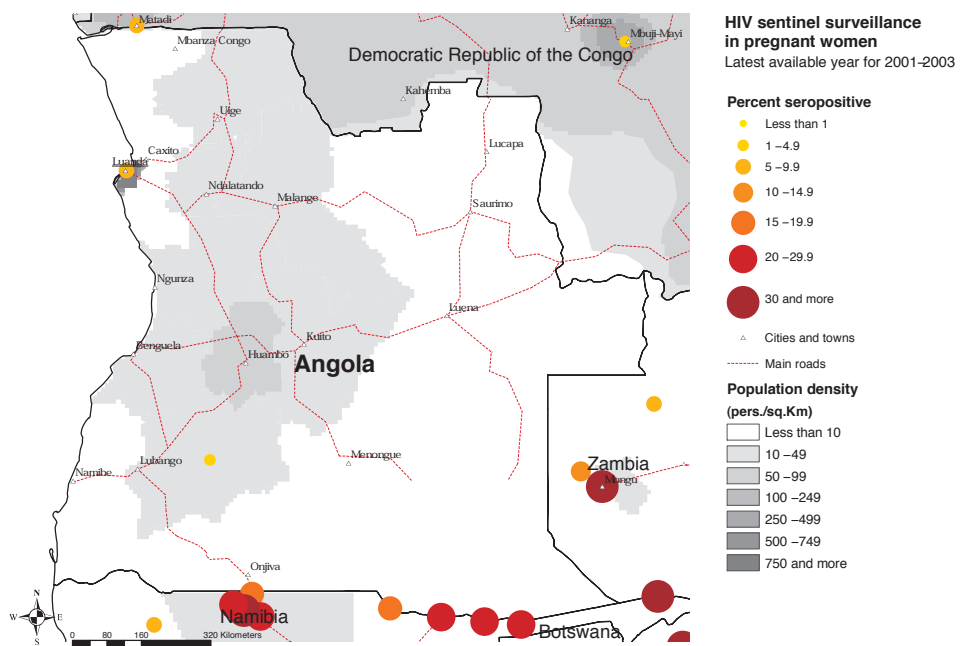


WHO estimate of number of people requiring treatment – end 2005: 32 000
 Antiretroviral therapy target declared by country: 5 500 by 2005



1. Demographic and socioeconomic data

	Date	Estimate	Source
Total population (millions)	2004	14.1	United Nations
Population in urban areas (%)	2003	35.3	United Nations
Life expectancy at birth (years)	2002	39.9	WHO
Gross domestic product per capita (US\$)	2001	700	IMF
Government budget spent on health care (%)	2001	5.5	WHO
Per capita expenditure on health (US\$)	2001	31	WHO
Human Development Index	2001	0.377	UNDP

3. Situation analysis

- **Epidemic level and trend and gender data.** The first case of AIDS in Angola was diagnosed in 1985. Until recently, national efforts to conduct sentinel surveillance were hindered by the ongoing armed conflict that has consumed the country since independence. As a result, information about the HIV prevalence among pregnant women attending antenatal clinics is scarce. According to government sources, 12 576 AIDS cases had been reported by the end of 2003, corresponding to about 10% of the estimated AIDS cases in Angola. This underreporting may result from inadequate perception of the magnitude of the infection and low levels of knowledge. According to UNAIDS, about 320 000 people 15–49 years of age were living with HIV/AIDS in 2001, and the adult prevalence was estimated to be 5.5%. This high magnitude of the epidemic is probably due to a lack of perception about risk combined with weak knowledge about prevention. In Luanda, where about 25% of the population resides, the estimated prevalence rate in 2001 was 8.6%. According to other studies conducted by WHO and other partners, the prevalence among sex workers in Luanda increased from 20% in 1999 to 33% in 2001.
- **Major vulnerable and affected groups.** Based on data collected and AIDS case reporting, the primary route of HIV transmission is heterosexual, with a male-female ratio of 1:1. Not only heterosexual transmission is responsible for the spread of HIV in the country. Based on cumulative data (1985 to March 2004), 15% of AIDS cases were caused by mother-to-child transmission of HIV, 16% by needles and other medical devices and 18% by blood transfusions. The distribution of people living with AIDS (also cumulative) demonstrates that about 60% are 20–39 years old, the age group with

2. HIV indicators

	Date	Estimate	Source
Adult prevalence of HIV/AIDS (15–49 years)	2003	1.6 – 9.4%	WHO/UNAIDS
Estimated number of people living with HIV/AIDS (0–49 years)	2003	97 000–600 000	WHO/UNAIDS
Cumulative number of reported AIDS cases	2003	12 576	Ministry of Health
Reported number of people receiving antiretroviral therapy (15–49 years)	June 2004	700	WHO
Estimated total number needing antiretroviral therapy in 2005	2003	32 000	WHO/UNAIDS
HIV testing and counselling sites: number of sites	2004	12	WHO
HIV testing and counselling sites: number of people tested at all sites		not available	
Prevalence of HIV among adults with tuberculosis (15–49 years)	2002	25.9%	WHO

the greatest contribution to economic productivity in Angola. Women 15–39 years old have a high burden of cases and women 40–59 years old a lower burden. This situation could be attributed to the advent of early and frequent sexual activity among women, to the imbalance in gender power and to the increase in sex work among young women because of high levels of poverty. According to Angola's national strategic plan on HIV/AIDS for 2003–2008, vulnerable groups are those that are potentially exposed, individually and collectively, because of structural, institutional, political and cultural variation that makes them susceptible to infection with HIV/AIDS. Using these criteria, the following vulnerable groups were identified: sex workers, truck drivers, mineworkers, military personnel, youth, street children, pregnant women, dislocated people, refugees and resettled populations, prisoners, drug users, blood transfusion recipients, traditional healers and traditional birth attendants, health workers and children infected and affected by HIV, including orphans.

- **Policy on HIV testing and treatment.** National guidelines on integrated care for people living with HIV/AIDS need to be developed, and the tools for delivering antiretroviral therapy need to be simplified and standardized as much as possible. There are limitations in the government's ability to develop health policies tailored to needs in accordance with the resources available.
- **Antiretroviral therapy: first-line drug regimen, cost per person per year.** Zidovudine + lamivudine + nevirapine (US\$ 172) plus nelfinavir (US\$ 358), total US\$ 530.
- **Assessment of overall health sector response and capacity.** According to official data, about 65% of the health units were destroyed during the war. Factors



such as the massive destruction of the health network, the deterioration of the socioeconomic fabric, the great population movement and the diseases related to HIV/AIDS are all at the root of the worsening health status of the people in Angola. Some of these factors further explain the poor capacity of the services to detect and treat other chronic diseases, including leprosy and trypanosomiasis. The proportions of staff posts in government health services are: physicians: 10–15%; registered nurses: about 40%; and others: 50%. Angola has a lack of professional resources capable of resolving matters within the health system, mainly at the primary level. Only 30% of the population has access to health services.

- *Critical issues and major challenges.* In the post-war context, Angola is facing various challenges in combating poverty and famine, reconstructing economic and social infrastructure, socially reintegrating demobilized military personnel and promoting national economic development. The institutional capacity of the National HIV/AIDS Programme and human resource capacity across the health sector as a whole urgently need to be strengthened. Additional support is needed in management, human resource planning, planning for the development of antiretroviral therapy capacity, procurement and national supply chain management and community preparedness and understanding.

4. Resource requirements and funds committed for scaling up antiretroviral therapy in 2004–2005

WHO estimates that the total funding required to support scaling up antiretroviral therapy in Angola over 2004–2005 to meet the WHO “3 by 5” treatment target of 16 000 people is between US\$ 27 million and US\$ 40 million. Of this amount, government commitments to scaling up antiretroviral therapy are estimated to be about US\$ 7 million. Bilateral funding over the same period is expected to provide about US\$ 2.7 million. Taking into account funds committed to date to support scaling up antiretroviral therapy, WHO estimates that the total funding gap for Angola to reach 16 000 people by the end of 2005 is about US\$ 18–31 million.

5. Antiretroviral therapy coverage

In 2003, WHO and UNAIDS estimated Angola's total antiretroviral therapy need for 2005 to be about 32 000 people, and the WHO “3 by 5” treatment target for 2005 is 16 000 people (based on 50% of need). The government has declared a national treatment target of 5500 for 2005. The government plans to support the delivery of antiretroviral drugs for 2000 people in 2004, with plans for an additional 1000 people in 2005.

6. Implementation partners involved in scaling up antiretroviral therapy

- *Leadership and management.* The Ministry of Health provides leadership in implementation coordination, national plan development, national human resource planning and programme evaluation with support from WHO. UNDP contributes to financial management activities, and the United States Centers for Disease Control and Prevention contributes to determining the cost of scaling up and raising funds to achieve this.
- *Antiretroviral therapy service delivery.* The Ministry of Health manages and leads all activities related to delivering antiretroviral therapy services with assistance from WHO in supply chain management, capacity-building, training, developing guidelines and testing and counselling. UNICEF contributes to capacity-building activities. Organizations supporting the implementation of voluntary counselling and testing centres include: the Portuguese Institute for Preventive Medicine; Population Services International; the United States Centers for Disease Control and Prevention; GOAL (a nongovernmental organization based in Ireland); CAJ-JIRO (Centro de Apoio aos Jovens, or youth support centre); Marie Stopes International; Divine Providence Hospital; the Sisters of Teresa; and national nongovernmental organizations. Additional partners in this effort include British Petroleum, Esso, the Rufford Foundation and the Spanish Agency for International Cooperation (AECI).
- *Community mobilization.* The Ministry of Health leads activities related to adherence and psychosocial support as well as material support, including nutrition. Additional assistance is needed in building capacity among people living with HIV/AIDS and in programme communication.
- *Strategic information.* The Ministry of Health provides leadership in all areas related to strategic information, including monitoring and evaluation, antiretroviral resistance and operational research and is supported by the United States Centers for Disease Control and Prevention in these efforts. WHO and the United States Centers for Disease Control and Prevention provide support to the Ministry in surveillance.

7. WHO support for scaling up antiretroviral therapy

WHO's response so far

- Supporting the development of proposals to the fourth round of funding of the Global Fund to Fight AIDS, Tuberculosis and Malaria with key partners, including UNDP and UNAIDS
- Providing technical assistance to support “3 by 5” efforts in planning, care and treatment, voluntary counselling and testing and partners' involvement
- Through the WHO/Italian Initiative on HIV/AIDS in Sub-Saharan Africa, supporting the strengthening of the capacity of health systems in establishing a sentinel surveillance system for HIV/AIDS as well as improving case management of sexually transmitted infections and voluntary counselling and testing services, and improving laboratory capability in testing for HIV and sexually transmitted infections

Key areas for WHO support in the future

- Establishing a “3 by 5” country team in the WHO Country Office to support the government and other partners in scaling up antiretroviral therapy
- Supporting the development of a national operational plan for scaling up antiretroviral therapy
- Assisting in developing a plan for procurement and supply management of antiretrovirals and HIV/AIDS diagnostics
- Assisting in training physicians, nurses and community health leaders in testing and counselling as well as care and support
- Providing technical support for provincial supervision in capacity-building for scaling up antiretroviral therapy

Staffing input for scaling up antiretroviral therapy and accelerating prevention

- Current WHO Country Office staff responsible for HIV/AIDS and sexually transmitted infections include one National Programme Officer for HIV/AIDS, and the recruitment of an international “3 by 5” Country Officer is currently planned.
- Additional staffing needs identified include international medical officers with background in antiretroviral therapy and HIV to assist the Ministry of Health in training physicians, nurses and community health leaders; and an international logistician to work on procuring, distributing and monitoring antiretroviral drugs and other supplies related to scaling up antiretroviral therapy, working with the Ministry of Health to strengthen the supply subsystem.

For further information, please contact:

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This country profile was developed in collaboration with national authorities, the WHO Country Office for Angola and the WHO Regional Office for Africa.

