

**A CULTURAL APPROACH TO
HIV/AIDS PREVENTION AND CARE**

UNESCO/UNAIDS RESEARCH PROJECT

ANGOLA'S EXPERIENCE

COUNTRY REPORT

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PREFACE

The failure of prevention campaigns is not only a result of institutional factors. Social and Cultural factors also play an important role in the spread of the disease. In addition, AIDS is a disease that does not effect solely the health sector. Since it also effects the productive sector of the population, this disease could have unforeseeable consequences on the socio-economic development of a country.

This study analyses the institutional responses to AIDS and the effects of the disease on people from different economic backgrounds. It encompasses population groups that are active participants of the country's production process and those most vulnerable to the spread of the disease. An analysis is also made of the many socio-cultural factors that facilitate the spread of AIDS. Moreover, a case study is elaborated in which people's attitudes towards such factors are explored as well as the changes in behavioural patterns that the situation demands.

LIST OF ABBREVIATIONS

ASDI	Autoridade Sueca para o Desenvolvimento Internacional
CAOL	Coordenação do Atendimento Obstétrico de Luanda
PHC	Primary Health Care
DDA	Doenças Diarreicas Agudas
DFID-UK	Department for International Development - United Kingdom
DNAGO	Direcção Nacional da Administração e Gestão do Orçamento
NPHD	National Public Health Direction
PHD	Provincial Health Delegation
DR	Diário da República
STD	Sexually Transmitted Diseases
UNFPA	United Nations Population Fund
GURN	Governo de Unidade e Reconciliação Nacional
HTP	Health Transition Project
IEC	Information Education and Communication
NSI	National Statistic Institute
MICS	Multiple Indicators Cluster Survey
MININT	Ministry of Internal Affairs
MINHE	Ministry of Health
ODA	Overseas Development Administration - United Kingdom
OGE	Orçamento Geral do Estado
WHO	World Health Organisation
NGO	Non-Governmental Organisation
EVP	Extended Vaccination Programme
PIB	Produto Interno Bruto
UNDP	United Nations Development Programme
PSPE -UE	Projecto de Saúde Pós-Emergência (União Européia)
SFSM	Síndrome Febril Suspeito de Malária
AIDS	Acquired Immune Deficiency Syndrome
SIS	Sistema de Informação de Saúde
NAP	National AIDS Combat Programme
SMI	Saúde Materno-Infantil
UAN	Universidade Agostinho Neto
EU	European Union
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNHCR	Alto Comissariado das Nações Unidas para os Refugiados
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
HIV	Human Immune Deficiency Syndrome

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OVERALL INTRODUCTION

1. Study's Context

The first HIV/AIDS cases in Angola were diagnosed at the end of 1985. Since then, and despite the measures to prevent the spread of this disease conducted by the National AIDS Combat Programme (NAP), the number of cases has increased continuously. According to the data provided by this Programme, from 1985 to March 1998, 2401 AIDS cases were registered throughout the country. As in other Sub-Saharan countries, the main vehicle for the transmission of AIDS was through heterosexual relationships - 47.9 % of the cases.

Since heterosexual transmission is the main way in which the disease is spread in Angola, we could assume that its rise is not just due to standard individual contact, but is also affected by migratory movements. HIV/AIDS is widespread within different social groups. This fact suggests that there are other reasons intrinsic to each group that contribute to the spread of the disease. Heterosexual transmission depends to a large extent on the personal and social framework in which people live. Indeed, social, economic, and institutional factors affect individual sexual behaviours.

The study of socio-cultural aspects, relevant to this present study, was carried out on the request of the UNESCO delegation based in Angola within the framework of UNAIDS activities. It was a very pertinent request as the great majority of health programmes, in particular the AIDS Combat programme, do not consider such factors which are crucial to the success of these programmes.

According to Foucault (1984) quoted by Rwenge (1996), sexual behaviour is determined by socio-cultural rules and values. It is the range of these rules and values that determines the circumstances in which individuals develop their sexual activity. In turn, each socio-cultural framework corresponds to specific sexual behaviours resulting from the learning and absorption of these rules, which are intrinsic to this framework.

2. Objectives

In general, we plan to:

- Evaluate the socio-cultural impact of efforts made to prevent and fight AIDS.

Specifically we desire to:

- Identify cultural rules, traditions, beliefs and practices that play an important role in the spread of diseases, particularly of HIV/AIDS;
- Identify social groups that have an important role within the development process and are vulnerable to the spread of the epidemic;

- Propose some measures to improve the implementation of activities to fight HIV/AIDS, taking into account the cultural aspects of people.

3. Work Content

This work was divided into four parts. The first encompasses the institutional mechanisms used in the fight against HIV/AIDS in Angola, focusing on the National AIDS Combat Programme.

The second part presents a brief analysis of ongoing relations between the HIV/IDS epidemic and socio-economic development. It also covers the main groups within the population that are most vulnerable to the spread of the epidemic and play an important role in the developmental process of the country.

The third part analyses the impact of socio-cultural factors on individual sexual behaviour, as well as the way in which such behaviour can facilitate the spread of HIV/AIDS among the population.

The fourth part presents a case study on some sexual practices which encourage the spread of the disease, as well as the changes in behaviour that are needed for prevention. Finally, this paper presents some recommendations.

4. Study's Constraints

Angola is not familiar with studies that make an objective explanation of the character of its population, either from a demographic perspective, or from a social, economic and anthropological outlook. A few anthropological studies were made during the colonial period. Yet, despite their undoubted value, their analyses were generally superficial.

Although the majority of the Angolan population consists of Bantu people, there will always be cultural aspects, specific to each sub-group, that determine particular sexual behaviours. These aspects need to be explored in order to develop strategies that are more appropriate to the needs of those sub-groups.

Another limiting factor that restrained this study was the time available for its completion. For instance, because a specialised bibliography was not available to us, in addition to the social and economic instability of the country, there were constraints to carrying out quantitative studies.

It is important to highlight that the group had some difficulties in obtaining statistical information, about the evolution of the epidemic in the country, from the National AIDS Combat Programme. This lack of information limited the description of the problem of AIDS in Angola.

PART 1: INSTITUTIONAL ASSESSMENT

1. Introduction

The approach taken towards the prevention of Sexually Transmitted Diseases including HIV/AIDS requires a thorough understanding of the patterns of action carried out by national institutions. This is necessary since AIDS is not only an issue that concerns the health sector, but affects other aspects of a nation's life.

In this section an analysis will be made of institutional commitment to the prevention of and fight against AIDS, particularly that of the National AIDS Combat Programme.

Before going into the details of the subject-matter, an overview is given of the social, demographic, economic and health situation in the country. This introduction is a *sine qua non* to assist in understanding the context in which the AIDS epidemic continues to grow in Angola.

2. Geographical Location

The Republic of Angola is, after the Democratic Republic of Congo (former Zaire), the biggest country in Sub-Saharan Africa. Located in the Southwest part of Africa, it covers an area of 1.246.700 Km² and is divided into 18 provinces. The capital is the city of Luanda. Its boundaries are: in the north, the Democratic Republic of Congo and Republic of Congo Brazzaville; in the south, Namibia; in the east, the Democratic Republic of Congo and Zambia; and in the west, the Atlantic Ocean. Angola is the biggest Portuguese speaking country in Africa.

The climate is diverse. Its relief and topography offer a great potential for agriculture. There are many mineral resources, such as oil, diamonds, iron, gold.

3. Social and demographic features of the Angolan People

3.1 Available Statistic Data

There is a lack of information in Angola at all levels caused by the difficulty of collecting data pertaining to the social, demographic, economic and health characteristics of the population.

The last census was taken in 1970. After Independence, an attempt was made to address the scarce information and execute a general demographic census. However, due to the

situation caused by the ongoing conflict, the government decided to limit the census to those provinces that were not directly affected by the war¹ (from 1983 to 1987).

The country has never carried out a national survey concerning health issues. For example, Angola is listed among the few countries where there has not yet been a health and sanitation survey that would provide information on the social, demographic and health characteristics of its population.

As part of the implementation of the Structural Adjustment Programme, the National Institute of Statistics (NIS), supported by several UN agencies, above all the UNICEF, has carried out a succession of socio-demographic surveys to assess the impact of this programme on living standards at a household level. Those surveys included some questions regarding health, particularly among children. Nevertheless, for different reasons, the data gathered has not been sufficiently analysed.

3.2 Population

According to the data published in the UNDP Report 1997, the Angolan population was estimated in 1996 to be around 12,865,420 inhabitants, with 50% of the population living in urban areas. The demographic density was estimated at 9,6 hab/Km², less than the average in Sub-Saharan Africa as a whole (21 hab/Km²). The population is very young: 44.9% are under 15 years of age. The age group above 65 years old represents no more than 3.0% of the total population. This is a result of the strong fertility rate that has prevailed in the country for several years. The population growth in Angola is considered to be one of the highest in the world, 2.8% per year. This percentage is similar to the average estimated for the continent (3,0%, United Nations, 1995).

Regarding migration, the country does not have reliable statistics of any kind. However, it seems that due mainly to the war situation there are 1.2 million people displaced throughout the country (UNDP, 1997), of whom 80% are women and children. This displaced population is concentrated, above all, in the urban centres and provincial headquarters. Luanda, capital of the country, has been particularly attractive due to its relative military stability.

There is no reliable information on the process of urbanisation in the country. Nevertheless, UNDP estimates that 50% of Angolans lived in urban areas in 1996. During 1990-1995, the percentage corresponded to 35% according to the estimates of the Population Division of the United Nations.

The literacy levels of the population are low, above all in rural areas and there is a considerable gender gap: 58% males and 28% females. Some population issues, which

¹ As a result of the Civil War, the census was limited to the provincial capital cities and to some cities under control of the government based in Luanda.

paid special attention to the sexuality of youth and information on HIV/AIDS, appeared in some school curricula. This project, run by the Ministry of Education with the support of UNFPA, was started in 1991.

Marriage and concubinage are common practices in Angola and thus the fertility rates are high. There are few cases of perpetual celibacy and childless couples. Thus, marriage occurs early: around 95% of males and 94% of females (above 50 years of age) are married or living in concubinage. The average marriage age is estimated at 23.5 years for men and 18.5 for women. The age difference in the first marriage or concubinage between men and women oscillates from 4 to 5 years or more.

The Angolan household is characterised by the extended family and this can contribute in part to the high fertility levels. The UNDP estimates the Synthetic Fertility Rate to be around 6.5 children per woman.

Traditionally, polygamy is culturally accepted for reasons that have more to do with economics than sexuality. Due to the social and economic changes, Angolans have faced in the last years, new forms of polygamy have emerged in which couples do not necessarily live together and women are more independent.

Regarding mortality, although the data is not completely reliable, the results of surveys recently carried out by the National Institute of Statistics point out that the rates of mortality in Angola are extremely high. For instance, the life expectancy was estimated at 42.4 years, being 44.2 for women and 40.7 for men (NIS, 1996). Compared to other countries, Angola presents the second lowest life expectancy after Sierra Leone where it is only 34 years (World Population, 1996).

The following table, presents a summarised demographic profile of Angola for 1996 according to the data published by the UNDP.

Table n° 1 - Angola Demographic Profile
UNDP, 1996

Indicators	Estimate
Total Population	12.865.420
Population Density (hab/Km ²)	9.6
Population under 15 years old (1/100)	44.9
Proportion of Urban Population (1/100)	50.0
Annual Growth Rate (1/100)	2.8
Gross Mortality Rate (1/1000)	19.2
Infant Mortality Rate (1/1000)	118.0
Mortality Rate under 5 years old (1/1000)	284.0
Mother Mortality Rate (1/100000 births)	1.500
Life expectancy	42.0
Gross Birth Rate (1/1000)	47.2
Total Fertility Rate children/woman	6.5

Source: Human Development Report, UNDP, 1997

4. Socio-economic Situation

After independence, the government decided to develop the country according to the socialist system, which based the Angolan economy on centralised planning, state ownership of the means of production and governmental control of all economic activities. However, the Angolan economy was very affected at first due to the withdrawal of Portuguese capital and, then, due to the direct and indirect consequences of the war. In fact, the country has been living through a war that has now lasted for over 30 years², this has depleted very important social and economic resources. The majority of social and economic infra-structures such as hospitals, health centres, schools, factories, and so on have been partially or totally destroyed in both urban and rural areas.

During this period, more than 50% of the General State Budget (GSB) was allocated to national defence.³ As a result, the proportion of the GSB sent to other sectors pertaining

² Angola faced 14 years of war against the Portuguese colonialists (from 1961 to 1974) and later a civil war that started even before the independence in 11, November, 1975. This war was interrupted in 1991 after the Agreement of Bicesse (Portugal) between the Government and UNITA. The confrontation resumed in 1992 after the publication of the results of the first multi-party elections.

³ For example, in 1993, 47,8% of the GSB addressed defense and public order and only 3.3% , health (Organização Mundial de Saúde, 1994, Saúde em Angola: Ponto de Situação, Luanda, OMS, p. 5).

to social issues such as education and health has been reduced over the years. Moreover, the war greatly affected production in rural areas thus leading to the current stagnation of the agriculture sector, which is the recognised basis of the Angolan economy. Thus, Angola is no longer self-reliant in food nor an exporter of agricultural products.⁴ Currently the national economy depends mainly on oil exports.

The government created a market economy as a result of the severe socio-economic crisis, exacerbated by the on-going conflict and due to changes that have occurred on a global scale in the both economics and politics⁵. Since the end of the 1980s, the government has endeavoured to implement the Structural Adjustment Programme, with the support of the World Bank (WB) and the International Monetary Fund (IMF). However, certain changes occurred that actually aggravated social conditions and poverty throughout the country. Unfortunately this coincided with the moment in which the population began to feel the negative effects of the implementation of this Programme.⁶

Indeed, there has been a tremendous increase in the cost of living which has led to the growth of poverty among the population. According to the Report on the Poverty Profile in Angola⁷ (INE, 1996), 61% of the households interviewed were under the poverty line and 11% were living in conditions of extreme poverty. The results of this survey also show that poverty is a generalised phenomenon and affects all regions of the country. The indicators of inequality in the distribution of resources among the different groups interviewed show high levels of inequality, above all in Luanda.

Nowadays, the economic situation of the country is very serious. The public and private sectors do not employ the great majority of productive age persons. Unemployment and, above all, underemployment have reached frightening rates in urban centres. Most people depend on the informal sector of the economy.⁸ According to the results of the above mentioned Poverty Report, 34.5% of the interviewed households depended on this economic sector in 1995.

Concerning human development, Angola occupies the 160th position (corresponding to a value of 0.323) according to the more recent calculations conducted by the UNDP.

⁴ During the colonial period, Angola was a self-sufficient country for basic food and besides exported several agricultural products such as coffee (Angola was the fourth main coffee exporter in 1974), manioc, banana, cotton, maize and so on.

⁵ At stake here are the changes observed in East Europe.

⁶ These programmes regarding to social development projects jeopardise the human development for their main goal is economic growth.

⁷ This report was based on data from the survey about household life conditions (known as Poverty survey) carried out in 1995 in Luanda, Benguela, Cabinda, Lobito, Luena, Lubango, as well as rural areas nearby these cities. 5.783 households were interviewed.

⁸ This sector creates several goods and services on which a great part of population depends. Despite its low capital, it creates jobs mainly for non-skilled people.

Compared to other countries in Southern Africa (UNDP, 1996), Angola still lags behind countries like Malawi and Mozambique.⁹

5. Health in Angola

5.1 General Health Situation

After independence, the government pursued a policy for Primary Health Care (PHC) as the basis for a system of health care services for the population in which medical assistance and medicines were free of charge. The health situation has worsened since 1980 because of the socio-economic crisis the country has faced and the intensification of the war that has limited the budget allocation to health: from 1988 to 1994, the budget of the health sector was reduced 50% as observed in the next table.

Table n° 2 - Percentage of the Estate Budget towards Health (1988 to 1993), Angola

Year	Budget(%)
1988	6.3
1989	6.3
1990	5.7
1991	3.3
1992	3.4

Source: WHO, 1994

This situation jeopardised the health sector: the preventive health programmes, such as PV, SMI/PF, DDA, PRN, HIV/AIDS), now depend on external funds and humanitarian aid.

The current health situation of the country is extremely perilous considering the increasing degradation of the health services infra-structure, and the lack of skilled staff, medicine and equipment. Access to health services is extremely difficult and limited.¹⁰

Existing data on specific causes of mortality shows that the majority of deaths are caused by diseases related to the condition of the local environment (access to drinking water and sewage), as well as malnutrition and vaccine preventable diseases, both especially high among children. There are several things that contribute to the deterioration of the general conditions of life and health of the Angolan people, particularly children and women. These are: environmental degradation, the low level of literacy among the general population and particularly women (especially important in the case of mothers), the dwindling quality of health services and the direct and indirect consequences of the

⁹ Malawi occupies the 161^a position and Mozambique, the 166^a one.

¹⁰ It is estimated that only 30% of the total population has access to health services including a gap between urban and rural areas (KODI-SAMBA, Constantino (1994), "Angola" in: La Démographie de 30 Etats d'Afrique de l'Océan Indien, Paris, CEPED, p.50-57.)

war. The improvement of the health standards of the population requires the substantial socio-economic development of the country.

5.2 Organisation of the National Health System

The National Health Service was created in 1975 (Law 9/75). Today it encompasses the following subsystems: Public Subsystem supervised by the Ministry of Health (MINHE), Military Public Subsystem, represented by the Angolan Army Health Service, Faculty of Medicine, non-profitable Private Subsystem (NGOs and churches) and the profitable Private Subsystem (private clinics).

Until 1991, health care for the population was controlled by the public sector including free medical assistance and medicines. In August 1992, the Basic Law of the National Health System was promulgated, defining a new orientation for the health sector, this culminated in the employment of medical assistance and medicine to other sectors.

5.3 Administrative and Functional Organisation

Administratively, there are three levels to the organisation of the National Health System: the periphery level under the co-ordination of Health Municipal Delegations, medium level co-ordinated by the Health Provincial Delegations and central level under co-ordination of the National Directions of MINHE.

Functionally, health assistance to the populations is based on the principles of the Primary Health Care (PHE) adopted in 1978 by the International Conference of Alma-Ata. (Table n° 3)

Table n° 3 - Organisation of medical and medicine assistance in Angola

Health Care in Angola	Institutions
Primary Assistance	Health Centres and Posts
Secondary Assistance	Municipal and Provincial Hospitals
Tertiary Assistance	National Hospitals and Specialized Institutes

5.4 National Health Policy

The general lines of the National Health Policy were defined in the Basic Law of National Health System (Law 21-B/92) which still needs to be supplemented by regulations on several basic aspects. The ongoing sectoral policies (Human Resources, Information System, Infra-structure, etc.), as well as the elaboration of the Sectoral Plan for the triennial 1999-2001 have the support of the WHO, Health Transition Project (HTP), European Union and the World Bank.

The MINHE is (according to the law 2/85) the governmental organism that executes and controls the National Health Policy in Angola. The act 8/76 (Republic Dairy, 1^a Category, n° 43, February 21) guides some aspects of this policy.

5.5 Primary Health Care System Management

The National Public Health Direction (NPHD), through its health programmes, ensures the implementation of the primary health care, as well as the National Endemic Control Direction for the control of malaria, tuberculosis, leprosy, schistosomiasis and other endemic.

The Primary Health Care (PHC) is based on three levels of the National Health System (NHS). These levels through programmes framed within the health structure represent the elements of the PHC. The administrative and financial management of these programmes is still centralised and its vertical implementation prevents their integration at the operational level.

The health programmes depend mainly on the international community. Only those programmes such as the Extended Vaccination Programme (EVP), SMI/PF and PNLs, which receive donations and funds are able to conduct action on the field.

The health community actors (health promoters and traditional midwives) ensure the link with the community. The health educators who work for the MINHE are included within the administrative staff and earn a salary.

In general, the PHC is welcomed in the communities though they have not achieved significant improvements in health care so far.

Due to the high mortality rates, there is a tendency to privilege palliative actions, either secondary or tertiary in the detriment of health promotion and disease control and prevention.

There is no operational link between health and other sectors, such as agriculture, education, social welfare, finance, sewage, etc. to help in the execution of health care programmes.

The co-ordination between partners in the development of health is only at its beginning due to a lack of adequate co-ordination mechanisms. The NHS law foresees the creation of the National Health Commission. This Commission should co-ordinate the activities within the different sectors which are responsible for the population's health care. However this commission still has to be set up by regulation.

6. AIDS in Angola

6.1 General AIDS Situation

The rates of AIDS prevalence in Angola are unknown due to the lack of an efficient information system and serum-epidemiological studies. The first four cases of AIDS were reported in 1985 by the MINHE. The UNAIDS estimates that there were about 110,000 HIV infected people, 25,000 deaths and 19,000 orphans at the end of 1997. WHO estimates for the same period hold the rate of prevalence among adults between 15-49 years old at 2.12%.

6.2 Reported Cases

The only available data was published by the National AIDS Combat Programme (NAP) in its report of July 1998 (SERRANO, DUCELINA). A total of 2,606 cases of HIV were reported to the NAP. Among the 8011 HIV tests that have been conducted since 1985, 32.5% were positive.

Table n° 4 - HIV Test Results

HIV Test Results carried out between 1985-1998	
Positive	2606
Negative	5389
Doubtful	12
No result	4

Source: NAP, 1998

This number might be unrealistic, since estimates show that among the infected world population, 6 out of 10 male adults, 8 out of 10 female adults and 9 out of 10 children live in Sub-Saharan Africa. A total of 16,000 people are infected daily; of which 7,500 (47%) cases occur in Sub-Saharan Africa.

However, the high HIV/AIDS prevalence in neighbouring countries makes us believe that the rate in Angola has been underestimated.

6.3 Geographic Distribution

According to the NAP and the information on HIV/AIDS prevalence, which has been obtained at blood banks, the north of Angola has been the most affected region in the last five years: 8.4% in Cabinda (1993), 3.3% in Zaire, 2.1% in Lunda and 1.5% in Malange. The province of Huíla located in the south of the country has 2.9% (1993), Benguela (1993) 0.06%. This situation might have changed, taking into account the effect of

military and political instability that has provoked intense population movements, refugees, etc.

Since this information is based exclusively on the HIV test results from blood transfusion centres, it does not reflect the real dimension of the problem among the population.

6.4 *The Evolution of AIDS in Angola*

The number of reported cases has increased progressively, from the four cases in 1985 to 549 in 1997 (table n° 5). During the first semester of 1998, the cases reported were over half those reported during all 1997. This reveals the rapid evolution of the AIDS epidemic in Angola. The next table shows an apparent drop in the number of the cases in 1995. We believe that this situation is a result of the cases that were not reported.

Table n° 5 - Annual distribution of the 2606 AIDS reported cases in Angola between 1985-1998 (June)

year	n° cases
1985	4
1986	8
1987	36
1988	79
1989	90
1990	175
1991	123
1992	230
1993	262
1994	363
1995	132
1996	329
1997	549
1998	226
TOTAL	2606

Source: NAP, 1998.

This lack of information, which affects all types of health data, is a result of military instability, the difficulty of implementing healthcare measures, especially after 1992 (when the war resumed) and the lack of an efficient national information centre. For example, the NAP noticed that, in the Province of Luanda, there is a gap of 360% between the information reported at the Provincial Health Delegation and that which was sent to the National Public Health Direction.

There is a need for a joint data system on HIV/AIDS to cover all levels of information. Indeed, there are guard units that report to the Hygienic and Epidemic Department of the NPHD or directly to NAP, as well as other units which send their reports to the Provincial Health Delegation. It denotes a huge disorganisation within the information system which explains in part the low rates of reports.

6.5 Types of Cases Reported

Among the cases which were reported to the NAP, 63% were suspicious clinical cases and only 4% contacts. 27% of the cases did not have any reference that denoted serious shortcomings in the filling of the report form.

The low number of reported cases is probably a result of the non-existence of case surveys. These should be conducted whenever infectious diseases and STDs are diagnosed.

6.6 AIDS Gender Prevalence

Concerning the gender AIDS prevalence, 51% of the cases were observed among male individuals while 49% among females. Comparing sex and age, we notice that there is a higher percentage of infected women between 15-19 and 20-29 years than men. Nevertheless, there is a different picture with the age groups 30-39, 40-49 and 50-59 years: where men constitute the higher percentage of HIV cases. This distribution is a consequence of the fact that men marry much younger women. In addition, the economic crisis has produced a hidden type of prostitution, particularly in Luanda. This new phenomenon is called “*fenómeno das catorzinhas*”, meaning sexual relations between economically stable male adults and women under 20 years old.

6.7 Specific Group Situations

In 1990 HIV-1 prevalence was estimated in Angola at 1.3% in urban areas and at 14% within high risk groups. There were studies conducted at some public health centres in Luanda between 1994-1995. The NAP analysed the results that pointed to similar global values as those shown in the following table:

Table nº 6 - HIV Prevalence in selected groups, Luanda 1994/95

Selected groups	Nº of conducted tests	HIV-1 tests	positive %
Pregnant	695	7	1.0
Pregnant with STD	305	5	1.6
Blood donors	10.668	109	1.0
Hospitalized children	280	5	1.8
Child/teenagers & blood transfusion	100	1	1.0
Tuberculosis patients	379	30	8.0

Source: National AIDS Combat Programme

In Cabinda, the AIDS prevalence among pregnant women was estimated at 8.6% in 1992 while in Namibe, 0.5% in 1995.

6.8 Patterns of HIV Transmission

The predominant type of HIV transmission is heterosexual intercourse, representing 41% of the cases, followed by 17% caused by the utilisation of injections and 7.5% caused by blood transfusion (Table 7).

<i>Type</i>	<i>percentage</i>
Heterosexual	41,5%
Injections	17,5%
Non Specific	19,3%
Transfusions	7,5%
Hem/Depra	2,0%
Mother-child	12,0%
Homosexual	0,2%

This predominance of heterosexual transmission could be explained by the increase of prostitution caused by military and political instability. An increasing number of soldiers (young and very sexually active groups) have moved around the country extensively. There are also a high number of extremely poor refugees who end up using prostitution as a source for their livelihood. However there are also socio-cultural factors that play an important role in this mode of transmission.

Although the data reveals a relatively low rate of transmission through blood transfusions and its derivatives, we suggest that this factor must be taken into account due to the absence of HIV/AIDS sampling in most of the provinces.

7. Analysis of the National AIDS Combat Programme

7.1 Objectives and Strategies

The National AIDS Combat Programme (NAP) was created in 1987. As part of the Ministry of Health, the Programme is responsible for the development of actions to promote HIV prevention and fight against AIDS. It is supposed to work as a secretariat to the National Commission for AIDS Combat and the National AIDS Technical Commission.

The NAP aims at the following:

- 1- Evaluate the current situation and monitor the evolution of HIV, the clinical and socio-cultural aspects of the epidemic.
- 2- Inform and educate the sexually active population and children above 10 years old about the transmission and prevention of AIDS.
- 3- Prevent the transmission through blood and its derivatives.
- 4- Ensure the development of a laboratory net system able to undertake the sampling of HIV-1 and HIV-2, as well as to provide confirmation exams.
- 5- Reduce mother- fetal transmission.
- 6- Guarantee adequate treatment and counselling for HIV positive and AIDS patients.
- 7- Promote operational research during the implementation of the AIDS National Programme.

In order to reach these goals, the programme is based on the following strategic principles:

- 1- Multi-sectoral involvement to address the HIV infection.
- 2- Utilisation of the media to widely divulge the key notions about HIV/AIDS prevention.
- 3- HIV Prevention through the haemotherapy centres.

- 4- Prescription, treatment and counselling for STD patients.
- 5- Promotion of support and care for people that are HIV positive and AIDS patients.
- 6- Promotion of the use of condoms and the facilitation of their accessibility.

7.2 Primary Actions

For the development of its strategies, the NACP foresees a range of primary interventions that are well formulated, but which have been disturbed by military and political instability, the economic crisis, Angolan cultural diversity, the deterioration of the Health System and sanitary problems. These could prevent the implementation of the planned activities.

These are short-term actions that NACP is willing to carry out:

- 1- Advocate the creation of the National Commission for the Combat against AIDS and the integration of STD and HIV/AIDS prevention activities in other national programmes.
- 2- Elaborate the National Strategic Plan for STDs and HIV/AIDS.
- 3- Elaborate a programme for HIV and Hbs epidemic guard, integrated within the Epidemiological Guard National System (Project CIRPS/MINHE), including behaviour and serum-epidemiological studies.
- 4- Elaborate a programme for STDs within the NACP.
- 5- Reinforce the capacity of Provincial Haemotherapy Centres in order to guarantee the sampling of HIV, Hbs and Syphilis and the creation of mechanisms to control informal haemotherapy centres. In addition, it will pave the way for the promotion of a policy that controls the use of blood substitutes (colloids and crystalloid).
- 6- Based on the information to be produced by the Routine Information System (RIS) and through the KAP studies, to promote the Education for Health.
- 7- Promote the social marketing of condoms to increase their use.

The following are medium and long-term actions that NACP foresees:

- 1- Organise a service system to assist and care for HIV/AIDS infected people, such as orphans, widows and family.
- 2- Take into account the traditional healers and stake-holders in the management of HIV/AIDS, supported by a programme for community based health care.
- 3- Elaborate special programmes for commercial sex workers, particularly for infant and youth prostitution.
- 4- Motivate the active participation of the media in the prevention and combat against STDs and HIV/AIDS.
- 5- Concerning the budget, ensure the appropriate allocation of resources of the General State Budget, guarantee the utilisation of the allowances affected by one side or the other, decentralise the raising of funds towards the Provincial Delegations and promote resource mobilisation within the private sector.

7.3 Constraints

The NACP has to face and overcome great difficulties that prevent the normal development of its activities in order to achieve success for the above mentioned package of measures.

1- Management and Co-ordination System

On the one hand, the process of gathering data should be structurally included in a Routine Information Centre to register developed activities and diagnosis carried out by health institutions. On the other hand, a complementary information system should be implemented, either through surveys or studies about community participation. However, what is actually taking place is the duplication of efforts between the PNVE¹¹ and the NACP, despite their belonging to the same department.

Despite this duplication of actions, there is a lack of reporting. This is due to the fact that diagnostic tests are not available in all parts of the country. Another important problem is that data producers (those who do the diagnosis) including the institutions that assist patients, have insignificant roles in the process of gathering, reporting and utilising the data gathered in the production of useful information, within the National Health Service. To make it worse, there are no regular reports on other subsystems of the National Health System and, in addition the community is not included in the decision-making process.

¹¹ Translator note: There is no other reference to PNVE in the original paper.

Obviously this problem leads to a superficial knowledge of STDs and HIV/AIDS that can explain, in part, the ineffectiveness or failure of the efforts to achieve multi-sectoral agreements in the fight against the epidemic.

2- Financial Resources

The NACP should have as its main financial resource the General State Budget. However they are only responsible for staff payments. The Programme basically works with external funds. We understand that this is one of the major deficiencies of the NACP because donors have their own interests. In addition, the management mechanisms are hardly flexible regarding the other needs of the operational process, such as the provision of basic needs for the functioning of the programme, e. g., paper, pencil, telephone bill, fax, etc.

3- Human Resources

The Programme has seven superior and medium technicians at a central level. Along with their low level of professional skills, specifically regarding STDs and HIV/AIDS, they are affected by the current problem of “symbolic” salaries. This hardly satisfies their basic needs and reflects negatively on the efficiency of NACP actions.

At the provincial level, *“there is a enormous demand for technical skilled staff able to promote the participation of other health workers in the clinical and laboratory STD and HIV/AIDS diagnosis, as well as in the operational research studies either in social, epidemic or clinical areas.”*¹²

Likewise, the National Technical Commission for the Combat against AIDS does not work (the NACP should be the technical secretariat). Consequently, it is not possible to bring together the technicians and experts working in the different subsystems of the National Health System to promote a common objective - the control of the disease. Besides that, the lack of knowledge about the socio-cultural factors reduces the possibilities to achieve successful education on health actions.

4- Development of Diagnosis Networking

The Programme acknowledges the difficulties concerning this issue and points out that only 27% of the provinces (5/18) are able to carry out HIV tests. The only province that has laboratory autonomy is Cabinda which is supported by the Cabinda Gulf Oil. There is no system of laboratories because the National Public Health Laboratory does not have technical or material conditions to be considered as a laboratory of reference. The National Blood Centre strives to reduce the gap mentioned above. Nevertheless it needs

¹² UNAIDS: country profile, main conclusion and recommendations from the study carried out by the Provincial Health delegations about the implementation of the NPCA.

reagents. Previously, the quality control was conducted with the collaboration of the SBL from Sweden. However, today this collaboration no longer exists.

5- Training

The lack of an overall policy for the fight against AIDS is reflected in the formation and training of staff. The training has been ad hoc, with no previous evaluation of needs and priorities or early identification of required skills. On the other hand, there is no information on the total number of people to be trained at the different levels of the health services.

The training of trainers does not have continuity due to an insufficiency of planning of the follow-up activities, allocation of resources for these activities and monitoring conducted by trainers.

6- Education on Health

One of the objectives of the NACP is the promotion of IEC activities, using audio-visual materials to inform the population about the disease and to promote the use of condoms. However, the impact assessment of implemented actions has not been systematic. We understand that the education on health actions merely focus its message on the use of condoms.

7.4 Organisation of NACP in the Provinces

According to the survey carried out by the NACP, only 75.0% (12/16) of the provinces have NACP provincial centres and these work very irregularly. Only nine of the provinces, where there are such centres, have action plans that involve addressing conferences on education for health and distribution of male condoms. The shortage of funds explains the non-existence of other activities.

Concerning to the involvement of other sectors, only the provinces of Huambo, North Kuanza and South Kuanza have multi-sectoral commissions for STDs and HIV/AIDS, but again their activities are very limited.

1- Statistic Data

There is no organised data about AIDS in the provinces and according to the results of the survey mentioned above, only 68.7% (11/16) of provinces declared to have AIDS cases reported to the MINHE. Also, 55% (6/11) did not have any knowledge of the cumulative total of cases from the start of the epidemic.

Regarding the reporting system, the provinces often mentioned the scarce material available to undertake reporting on AIDS, while others do not send any information because they do not even have laboratories.

2- Central Level Support

The NACP support for the communities is very limited. The provinces complain mainly about the need for up-to-date information on the epidemiological situation of STDs and HIV/AIDS in the country, the scarcity of support material for health education and information for staff, the non-existence of staff training plans and the lack of laboratory materials, tools and regular monitoring.

3- HIV Tests

Apparently some provinces send serum to the National Blood Centre to HIV test in order to confirm laboratory tests carried out in their laboratories or hemotherapy centres as well as to test suspicious patients.

4- Haemotherapy

Only 27.0% of the provinces¹³ have haemotherapy services capable of carrying out HIV tests. However, even these provinces have interrupted the blood tests since they have run out of material due to the constant demand.

5- Material Resources

Regarding the availability of health educational resources for STD and HIV/AIDS, all provinces except Kuando Cubango, South Lunda and Moxico reported that they have some material, although not enough for the educational activities that they would like to undertake.

Male condoms are available in all provinces, except in Cunene and Moxico. However existing stocks are not regular and there are periods of scarcity.

6- National Norms towards STDs and HIV/AIDS conduct

Despite the inadequacy of an overall policy on STDs and HIV/AIDS, there are some norms that are known to the majority of the provincial public health representatives and directors that are:

- Definition of AIDS case;
- Hygienic and Sterilisation norms;
- Epidemic Guard Norms;
- Laboratory quality control norms for HIV tests;
- Transfusion Security norms;
- PWA treatment norms;

¹³ The provinces are Benguela, Huíla, Malange, Namibe and Cabinda.

- PWA counselling norms;

7 - Non-Governmental Organisations

There are NGOs that have developed some HIV/AIDS activities in the provinces of Bengo (ADPP), Bengela (ALSIDA and Nuova Fronteira), Bié (MSF), Huambo (SCF), Huíla (ADRA) and Uíge (CIC - Portugal). However there are no co-ordination mechanisms with the NACP provincial centres.

8. NACP Partners

8.1 *United Nations and other International Organisations*

The United Nations system created a Theme Group consisting of UNDP Representatives, UNICEF; UNFPA, UNESCO, WHO, World Bank, FAO and the UN High Commission for Refugees. The Ministry of Health is represented by the national director of the NACP. This group has among other objectives, the reinforcement of national abilities in the leadership, co-ordination, management and monitoring of the national response to the HIV/AIDS epidemic. The following describes the different partners of the government as well as the patterns of support they offer.

8.2 *Angolan NGOs*

The increasing civil society awareness toward the problem of AIDS could be evaluated through the emergence of NGO's¹⁴, beginning from 1992. It is important to mention that the majority of NGO's, despite being registered for national programmes, limit their activities to the province of Luanda.

The results of the survey we have conducted among the NGO's show that they have some difficulties to define their goals and strategic plans. They are also concerned about the non-existence of a national policy for the fight against AIDS that could guide their activities. The following is a list of programmes and projects carried out by these NGOs:

¹⁴ There are NGO's that carry out activities concerning exclusively AIDS issues (AALSIDA, AASIDA, AMSA, ELSIDA) and NGO's that develop other activities beyond AIDS (APV, AIA, ANGOBEFA, FISH).

Table n° 5 - NGOs Programmes and Projects

NGO	PROGRAMME	PROJECT
Grupo de Activistas Anti-Sida (GAASIDA)	HIV/AIDS prevention; counselling & IEC formation; diagnosis and treatment	HIV/AIDS prevention among the Police of the city of Sambizanga, in the city of Samba and in the districts of Kassekel and K. Kiaxi
Associação de Misericórdia e Solidariedade (AMSA)	Emergency & Rehabilitation of Public Health	Green Life; A Life with Hope; A Life, a Home
Clube Juvenil de Educação e Informação sobre o SIDA (EISIDA)		Training Seminars for teachers; Information and education on AIDS kiosks
Fraternidade para a Infância, Solidariedade e Humanismo (FISH)	Emergency package for teachers and sanitary education. STD and HIV/AIDS prevention, children and pregnant women attendance	Basic Education for underprivileged children
Acção pela Vida (APV)	Mahezwo Programme - STD and HIV/AIDS prevention	AIDS prevention at schools. The Street Children and the AIDS Production of information material and broadcasting programmes

The concept of unifying to mobilise resources can be found within the Angolan NGOs. Therefore, The REDE DAS ONG'S AO SERVIÇO DO SIDA (ANASO) was created in 1994 with the objective of bringing together the Angolans NGOs' efforts in the AIDS prevention and combat.

The ANASO has its headquarters in Luanda, working temporarily at AALSIDA. There are 8 NGOs members: half of them working specifically on AIDS issues and the other half developing activities regarding problems caused by AIDS.

Between 1994 and 1997, ANASO did not work due to internal organisation factors. From 1998 this association has worked collaboratively with the NACP and has already supported national NGOs. ANASO has given them the opportunity to share information, ideas and experiences, as well as has contributed to the training of NGO's leaders and staff in different subjects. Thus, NGOs have progressively established their credibility.

The internal and external growth could be observed during the seminar with the participation of the NACP and NGOs carried out between 12 and 14, January 1999. The seminar noticed the existence of structural and functional deficiencies basically caused by the lack of training and funds.

Conclusions

One of the factors that prevent knowledge about the rates of AIDS prevalence in Angola is the non-existence of a national structured information system. Furthermore, the lack of a definite national policy for fighting AIDS is a result of the inefficiency of the National Commission for AIDS Combat and National Technical Commission.

The National AIDS Combat Programme has faced many materials, technical and human hardships that prevent the Programme from achieving its objectives.

PART 2 : AIDS AND SOCIO-ECONOMIC DEVELOPMENT

1. Introduction

According to the literature on the topic, the AIDS epidemic advanced in three stages: the first stage, before 1980 in which the disease spread silently and went unnoticed; the second stage, in the beginning of the 1980's when the first AIDS case was identified and the third stage, from 1980 to the present. In this final stage the disease has turned into a public health issue with social, economic and political ramifications that threaten the socio-economic development of numerous countries, particularly in Africa.

The AIDS epidemic does not affect solely the health sector but all other sectors of economic life since it threatens people of a productive age directly. The following analysis of the economic consequences of AIDS will consider the overall effects on the economic development of the country: the deterioration of a population's health overall development prospects.

When AIDS affects people of a productive age, it also affects all potential economic development due to the absence of human capital. However, these effects must be reviewed when taking into account the Angolan social context which has been marked by a high levels of unemployment and underemployment. Therefore, the assessment of the economic consequences of AIDS must be a concern among all sectors of society. This should unify their efforts to implement effective strategies to combat the AIDS epidemic. Society as a whole should share the responsibilities in this fight that could otherwise overwhelm the government or the civil society.

The AIDS crisis has had a considerable impact on the productivity of different economic sectors, both at national or household levels. However, the effects within the family are more poignant and provide a more obvious warning, above all when the affected person is in charge of the family income.

2. AIDS Economic Consequences

2.1 The Industrial Sector

Since the colonial period, the Angolan economy has mainly been based on the agriculture sector, particularly, the production of coffee.¹⁵ However the industrial sector had achieved some development in the provinces of Luanda, Benguela, Huambo and Huíla. Nowadays, the industrial sector has little importance, except for the oil industry that has had an outstanding expansion.

¹⁵ However, after the independence and as a result of the increasing war action, this sector suffered a strong collapse which have led the country to depend on the oil exploration

AIDS will not have an impact on the different subsystems of this sector. As its prevalence could be more evident within those sectors in which workers are far from their homes for extended periods, such as in the oil and mine industries.

In general, considering that HIV/AIDS affects above all people in active age groups, the industrial sector could face production problems and scarcity of workers as observed in some central African countries. The disease causes worker absenteeism, low productivity and income, including the loss of skilled labour (workers die). This situation could seriously jeopardise the organisation of work. In addition, countries with a high HIV/AIDS prevalence among the population, above all the technicians, could face problems in replacing labour (DOZON, 1994).

2.2 Tertiary Sector

The tertiary sector, an important component of the Angolan economy which is run mainly by the government, could also be affected by AIDS. This epidemic does not affect solely people who are of the less educated or underprivileged social classes. According to Dozon, studies on Zaire, Tanzania and Rwanda show a positive correlation between the HIV prevalence and education, income and profession. In these countries, AIDS affects the decision-makers.

2.3 Household Agriculture Sector

The principle Angolan economic sector is agriculture. By affecting people of an active age, who are able to work in the fields, the epidemic could exacerbate the existing socio-economic crisis among those families that depend on this sector. The labour force would be reduced not only due to the absence of the ill, but also due to the absence of those family members who have to take care of them.

The changes in the recruiting and availability of labour could force families to move away from an income activity to mere livelihood production. This situation would reduce their income and further limit the capacity of external labour recruitment. Therefore the utilisation of child labour would force children to drop out of school. Low productivity jeopardises food security within households, causes malnutrition and interferes, above all, with education.

Due to the serious economic crisis and the lack of a structured social welfare system in Angola, the costs of education and health, which should be supported by the state, weigh upon the family budget. The costs of medical assistance and medicines regarding HIV/AIDS are very expensive and therefore unattainable, particularly, for poorer and underprivileged families.

For example, Davachi, quoted by Dozon, estimated that the cost of hospitalisation for a HIV+ child corresponds to around three times the father's monthly salary. Transporting

the patient and the family members who accompany her/him further increases these costs.

Due to the situation presented above, added to the fact that AIDS does not have a cure, underprivileged people can not properly assist the patient. They might even ignore the patient considering it useless to spend money on somebody already condemned to die. Certainly they might decide to spend their scarce resources on other family members who are healthy.

The reduction of family income could lead to a reduction of food allocations, clothing and education, meaning that children drop out of school earlier. This situation could be more serious among women who, in many cases, lose their right of inheritance from their husbands and are thus forced to go back to their original homes with their children.

2.4 Informal Sector

Due to the economic crisis, the majority of the population works in the informal sector where commercial activities predominate. According to some authors (Rwenge, 1996), this sector contributes to the development of high-risk behaviours, such as prostitution, drug use and so on. As we will see later on, youth, particularly young women, are the most susceptible. We emphasise this sector because many families depend on it for their livelihood. In addition, the mobility across the country of people working on commercial activities could exacerbate the spread of the disease within the country.

3. Most Vulnerable Social Groups to the Spread of the Epidemic

The HIV/AIDS prevalence is wide-spread among the different groups of the population. This diversity is a result of several social, cultural, economic and institutional factors. Considering the demographic, economic and health situation of the country, women, youth and children are the most vulnerable groups to the spread of the disease.

3.1 Women

AIDS affects all social groups, but women are particularly vulnerable and are the main HIV/AIDS victims due to their multiple roles as mothers, wives and workers.

In the current households and social groups in Angola, women have an inferior status compared to men and they are more vulnerable to the disease. Indeed, there are norms that rule gender relations and make women more susceptible. In addition, women must face severe economic difficulties due to limited access to material resources and low-incomes, particularly, among those families headed by women or in which they are responsible for the livelihood (Leite, J. 1995).

Besides being a very vulnerable group, women also represent a crucial resource in the fight against AIDS. Indeed, it is they who take care of the children and oversee their

education. Traditionally, women teach children and youth the cultural and social behaviour of the community. They often take care of AIDS patients within the household and give them psychological support. Since behaviour plays a very important role in the development of AIDS, evidently there is a need to mobilise women in the prevention of and fight against AIDS.

Traditionally, women are in charge of the ill. This role further burdens their daily activities and affects their reproductive capacity and their domestic duties, particularly the caring of children. As the health situation of the patient deteriorates, care becomes increasingly difficult, demands more time and causes emotional and physical exhaustion (Danin Dazinger, 1994). Due to this situation, women have quit some of their usual activities, namely the productive ones.

Besides the fact that women are in charge of the patient, they are also more exposed to the infection and thus subject to infection than men. The main reason for this susceptibility lies in the sexual behaviour of their husbands, because women are in a more submissive condition and, their weak power of “negotiation” within sexual relations. Furthermore, the mother to baby HIV transmission jeopardises their role as mothers, which is an important factor for their recognition within society.

A great effort should be set up to carry out conceptual and methodological research that considers all these aspects. These should be socially and culturally sensitive to better comprehend how women have understood and addressed AIDS prevention. In this way, there is a to formulate an appropriate conceptualisation and promote urgent political, social and economic changes.

Therefore, efforts must be developed towards the implementation of measures able to reduce the inequalities, discrimination and sexual antagonisms through the elimination of socio-cultural and, basically, economic inequalities of which women are still victims in Angola.

The risk of infection through blood transmission is also high among women, especially during their fertile period. The anaemia that results from certain pathologies associated with pregnancy and birth (infectious disease, haemorrhage, etc.) often requires blood transfusion. The lack of regular controls of blood and its derivatives exposes women to infection. The use of non-sterilised material in public and private health centres in the treatment of STDs and other gynaecological treatments further contribute to the spread of AIDS.

It is necessary to highlight a particular group among women: the prostitutes. Prostitution in Angola is basically caused by economic reasons. Difficult living conditions often exacerbate female prostitution. In the case of Angola, the long and deep economic crisis exacerbated by the on-going war has led to an increased migration to urban centres, above all, to Luanda. Due to unemployment, many young women end up prostituting themselves in order to make a living. Men, that are economically stable,

often take advantage of this situation to satisfy their sexual desires and thus expose the women to STDs and AIDS.

Women generally depend on their husbands, but when these can not make ends meet, women are often tempted to involve in profitable extramarital relations (a hidden pattern of prostitution). This behaviour is more common in urban areas, above all in households in which the husband is “responsible” for the family income.

However, Angolan women have changed their social conditions because of the socio-economic and cultural transformations observed in the country. Although education has played a very important role in improving their social status, it is still inferior to men. This educational ascension, which is seen as gender emancipation, might often provoke conjugal instability and marital mobility and forces an increasing number of women to act as the head of the households.

The above mentioned difficulties in the country have obliged most women to face serious hardships to satisfy the needs of their offspring and other members of the household. They have developed several strategies to survive, e.g. working in the informal economic sector. This economic sector constitutes an environment prone to prostitution. It is known that prostitution plays an important role in the spread of STDs including HIV/AIDS.

3.2 Youth

The Angolan population is essentially young - the average age is under 20 years. Youth represents a high-risk group to bring infected with the disease due to their ignorance of the subject. Among youth, we could emphasise the 15-24 year olds group that acquires high risk behaviour: this is a group with specific ways of tackling problems, above all those regarding sexuality; it is a group prone to risky sexual experiences, drug and alcohol abuse, among other practices.

Traditionally, the Angolan youth, particularly from rural areas, has practised rites of initiation. These rites introduce young men and women to sexual issues. The main objective of this ritual learning process is to prepare the youth for marriage and their individual and social roles as procreators. For example, the initiated boy shall have his first sexual experience with an adult woman (generally, a maternal or paternal aunt) who could explain to him the most adequate attitude to fulfil his role as a father and to inhibit distress (Altuna, 1993).

These pre-marital relations are considered as an important psychological preparation and acquisition of skills for the exercise of a man’s primordial role in society. Society, therefore, recognises these rites as rehearsals and a proof of his ability to be married.

Although society exerts a strong control on youth, particularly, regarding sexual life, this sexual education might be at the origin of certain abuses and sexual freedoms. Thus,

initiated youths could take a lover in secret. In some cases, young women who have been initiated and are no longer virgin feel freer to maintain hidden sexual relations.

Circumcision has the following objectives: to prepare the young man for physiological roles of fatherhood and to define his sexual role regarding marriage. This could be practised as part of rites of initiation into puberty (Altuna, 1993).

Clearly it is not necessary to point out that these traditional practices of initiation might act as an important “vehicle” in the transmission of HIV/AIDS among youth. People who play the role of “sexual initiators” could be infected without knowing it. Moreover, their knowledge about the patterns of transmission of the disease is very limited and they are almost entirely ignorant of methods of prevention. Circumcision, for example, often is carried out with material non-sterilised that could facilitate the transmission of the disease.

It is important to cover the army. The internationalisation of the conflict in our region has led to a great mobility of young Angolan soldiers in different countries. Some of these countries present high rates of HIV/AIDS prevalence that might increase the spread of the disease within our army if appropriated prevention measures are not taken. This situation might have negative results when the soldiers return to Angola. Then, the army medical services must make an effort to inform and educate the young soldiers about the HIV/AIDS transmission and prevention.

3.3 Children

Angolan children present a very vulnerable group to the spread of HIV/AIDS. Like women, anaemia as a result of some pathologies, above all infect-contagious and others inherited characters such as drepanocytosis, often exposes them to the disease. For the treatment of anaemia often requires blood transfusion and blood donors are generally adults (relatives or not). The HIV test is not regularly carried out even in Luanda. Therefore, children, who have received blood transfusions, run the risk of being infected.

The AIDS orphans constitute another major problem caused by this disease. In Angola, this aspect has been neglected by several of the organisations that should be in charge of them.

Today’s children will turn into the labour force of tomorrow. Those who are responsible for them then should protect them from the patterns of HIV/AIDS infection.

Conclusions

This brief analysis brings up that AIDS consequences are most evident at individual or family levels rather than at an overall perspective. However, if the epidemic continues to spread, the consequences at a national level might be devastating. The health sector will feel the effects inasmuch as a higher percentage of its budget is turned away to the chronicle patient's attendance within secondary and tertiary sectors.

The degeneration of the socio-economic situation of the country has allowed for the emergence of a situation that is propitious to the spread of STDs and particularly HIV/AIDS. Indeed, the generalised poverty, unemployment, the increasing illiteracy, the unavailability of food, the lack of basic social services all contribute to the spread of STDs, which are considered the major factor to disseminate HIV/AIDS.

PART 3 : SOCIO-CULTURAL FACTORS AND THE SPREAD OF HIV/AIDS

1. Introduction

The spread of HIV/AIDS is not only a result of population movement. Indeed, it contributes to the spread of the virus, however the predominance of transmission through heterosexual intercourse has led us to conclude that there are other reasons for the spread of HIV/AIDS, such as socio-cultural factors.

In this part, we will analyse the main socio-cultural factors that might play an important role in the spread of HIV/AIDS among the population. First, we will briefly characterise the main Ethno-linguistic groups that constitute the Angolan population.

2. Ethno-linguistic Composition of the Angolan Population

The Ethno-linguistic and cultural information on the Angolan population is very reduced. In fact, few studies were carried out during the colonial era. The colonial rules did not provide an incentive for research on social sciences. Since independence, no faculty of social sciences has been launched in the country.

According to the anthropological bibliography available on this subject, the Angolan population is very heterogeneous and consists of people from two different Ethno-linguistic families: the Bantu and the Khoisan. There are also the *mestiços*, generally of Angolan-Portuguese origin and some European descendants. Therefore, the main ethnic groups are the following:

2.1 Bantu Group

The Bantu constitute the majority of the Angolan population and are divided into nine large Somato-linguistic groups, that are: Quikongo (Bakongo), Quimbundu, Ovimbundo (Mbundu), Lunda-Tchokwe, Hereros, Ganguelas, Nhaneka-Humbe, Ambós and Xindongas. These nine groups are subdivided into around a hundred subgroups traditionally known as tribes.¹⁶ The Ovimbundo, Kimbundo and Kikongo represent together about $\frac{3}{4}$ of the Angolan population.

Until the beginning of the century 14th, the Bantu people were divided into independent kingdoms that shared similar cultural roots. This similarity has facilitated the communication among these people.

Bantu people inherited a common original language, despite several dialects that have originated in many Ethno-linguistic groups. These people are characterised by “diverse technology, an original style of sculpture, a range of notable empirical knowledge as well as a deep and very interesting oral literature that encompasses an outstanding intellectual expression” (Redinha, 1974). In general, polygamy is a common practice among Bantu

¹⁶ Find enclose a list of all ethnic groups in Angola.

families. Circumcision is practised either as part of the rites of male initiation or as a mere hygienic measure. The female initiation is also a component of their practices and habits.

2.2 Hogenote-Bushmen or Khoisan Group

According to Redinha, this group is the “*contemporary representative of the most remote Angolan populations*”. They are nomad groups scattered all over the south of the country among the Bantu population. This group is divided into two main subgroups: Yellow Bushmen (Mucuancalas and Cassequeles) and Black Bushmen (Vazamas or Cazamos).

Hunting and collecting constitute their two main sources of livelihood. Their political system is limited to the *kraal* leader who is elected among them and to the monogamous family. Adultery and the rupture of marriage are rare. There is no rite of male initiation and puberty is acknowledged by a simple ritual confinement.

2.3 Vátua Group (pre-Bantu)

This group is located in the semi-arid belt of the Namibian desert and has lived in Angola since before the arrival of the Bantu people. They practice polygamy, the circumcision and rite of female initiation, practices and habits are inherited from the Cuvale people. Regarding religious beliefs, they worship a Supreme Being and their ancestors. This group is divided into two subgroups: Cuissis and Cuepes.

In sum, the following are the contemporary ethnic groups in Angola organised according to a chronological order:

Hogenote-Bushmen Ethnic Group (non-black and non-Bantu people);
Vátua or Pre-Bantu Ethnic Group
Bantu Ethnic Group

Concerning religious beliefs, we find two major groups: Christians that represent about 53.0% of the population (being 42.0% Catholics and 11.0% Protestants) and traditional religion beliefs' practitioners - 44,0%. The Afro-Christians constitute solely 3.0% of the population.

3. Socio-Cultural Factors

Sexuality is not an isolated phenomenon. It covers norms and cultural values of each community, e. g., marriage practices, family and fecundity (Rwenge, 1996). Among these factors, we will analyse sexual education, the loss of traditional values regarding sexuality, post-birth sexual taboos, family structure within the household, types of marriage and the status of woman, as well as religious norms and values.

3.1 Sexual Education

The family education particularly regarding sex exerts an influence on behaviour of young people. However, considering the Angola case study, its discussion between parents and offspring is very rare in so far as sex is considered a “*taboo*” subject. The results of the study carried out in Luanda among teenagers between 14-20 years old show that most of the teenagers do not talk about sex with their parents. Generally, this subject is tackled among friends, school acquaintances or girlfriend/boyfriend (Leitão, Ana, 1997). According to some authors, parents avoid talking about these issues for it is considered a motivation to the early practice of early sexual experiences.

Another study conducted by WHO (1989) shows that sexual education at school could change the sexual behaviours youth, delay the age of starting sexual relations and increase the use of condoms. According to Rwenge, sexual education programmes at schools are more effective when social norms and responsibilities are highlighted. However, these programmes should be implemented before young people have had their first sexual experience.

3.2 Loss of Traditional Values regarding Sexuality

Traditional Angolan societies have suffered several changes as part of the “*modernisation*” process. These transformations have led to the loss of some traditional cultural norms and values that once influenced individual sexual behaviours. Urbanisation and formal education moved the individuals away from their groups. Then decisions regarding sex became an individual issue rather than a family or community subject (Locoh, 1988).

The socio-economic crisis has exacerbated these transformations. Nowadays we observe that elders have progressively lost their control over youth, as well as men over women. Some cases of family deterioration have forced children to leave their homes and live in streets where they have to set up their own survival strategies. Prostitution, the drug market, delinquency and other high risky practices and behaviours are prone to facilitate the spread of HIV/AIDS.

3.3 Household Factors

It is important, at this point, to stress that the idea of family in Africa, and consequently in Angola, is very complex due to the diverse of patterns of family organisation. The idea of family brought from European countries does not go Angola reality since it is strictly related to the socio-cultural context of each group, community and society (Sala-Diakanda, 1988). The traditional idea of family encompasses criteria of blood and marriage links, and sometimes housing simultaneously.

The family is the space in which children get along with their siblings, community norms and values are transmitted and social control is begun. (Locoh, 1988). Therefore, the family context influences sexuality to a large degree.

Likewise, kinship systems might influence the sexual behaviour. For example, in a matriarchy, the male sexual dominance over women is weaker because of her control over domestic production. Thus, this system contributes to autonomy and even independence of woman.

Concerning the structure of the household, Caldwell points out that the control over sexuality would be more severe in extended families in which, unlike nuclear families, various generations live together.

3.4 Factors associated to Patterns of Marriage

The traditional marriage system in Angola is similar to that of other countries in Sub-Saharan Africa. Generally, it is a result of family agreements and alliances rather than individual decisions. In many cases, its fulfilment, which requires a long period to be set up, is marked by ritual stages. There are several different rites according to each Ethno-linguistic group of the country.

The common age to become married or to have sexual relations is traditionally very early, above all among women. Indeed, rites of initiation during puberty contribute to precocious sexual activities.

Marriage and concubinage might influence individual sexual behaviours. Polygamy could promote extra-marital relations since polygamous men are more prone to extra-marital experiences rather than monogamous men. (Rwenge, 1996)

Some women within a polygamy relation also could be tempted to have extra-marital relations, above all when there is an age gap between the couple. According to Caldwell (1993), these women could consider their husband unable to satisfy them sexually or they could feel attracted to younger men.

The new forms of polygamy in Angola, particularly in urban centres, in which the couple does not share the same house and wives are economically independent, could also contribute to female extra-marital relations. Polygamy could also influence the sexual behaviour of young people for they might be inclined to imitate their parents' attitudes and habits.

The polyandry, system in which a woman can have more than one husband, is a common practice in some groups, but limited to the female leaders. These have the right to choose their husbands. If the chosen man is married, he must leave his home, even when he is polygamous to devote himself completely to the woman who offered him this honour. This woman has the right to choose occasional lovers (Altuna, 1993).

The marital instability observed today in Angola might also influence individual sexual behaviour. Man and woman could go through extra-marital experiences during conflictive periods. According to Pison (1988), marital instability and mobility are factors that enhance exposure to STDs, particularly HIV/AIDS. The conjugal instability and matrimonial mobility could also influence the child's behaviour.

A brief mention of the surrogate system is needed at this point.¹⁷ This refers to the marriage or union between the brother with the widow of a given man. Generally, the succession order goes from the youngest sibling to the eldest. This criterion for deciding is usually that he is single or when married, he does not have children. This election represents an honour to the successor and he is obliged to take the responsibility of his role as father and husband.

The surrogate is also the marriage between a widower and his youngest sister-in-law. The principles are similar to the case mentioned above. This practice is acknowledged as a proof of a good relationship between the couple and the two families.

These traditional practices are common among the different Ethno-linguistic groups in Angola, especially the Bantu. Taking into account that the main HIV transmission in this country is through heterosexual intercourse, these socio-cultural practices could spread the disease within a household, above all, among polygamous groups. In the case of the surrogate, the successor could be infected by the widow and then infect his other wives.

The traditional marriage in Angola covers a social, moral and religious purpose. For women it is a guarantee of economic protection. In a traditional environment, women have difficulty convincing their partners of the need to use a condom because of their submissive status. Since marriage means reproduction, condoms are seen as a contraceptive rather than as a form of STD and HIV/AIDS prevention.

Therefore, the ineffective and inefficient use of condoms constitutes a major constraint in preventing and fighting against AIDS. Indeed, the change of practices and behaviours, which are deeply rooted and part of traditional beliefs, is a time-taking and arduous process. This demands awareness among community leaders and decision-makers to act with a clear perspective (Salifsow, 1996).

¹⁷ This practice aims to safeguard the property left by the deceased and to protect his children. This fact is an advantage to the psychological development of the children or they will grow up with their father's relatives and in this sense, the impact of the death could be reduced. Therefore, the successor brother takes responsibility of his nephews. It is important to stress that if the widow rejects the succession, she runs the risk of going back to her original family without her children. This fact often compels women to accept such practice in order not to be separate from their children and to continue benefiting from the dead person's family economy.

The risk of infection does not manifest itself solely within the framework of traditional marriage practices. Indeed, the new husband runs the same risk of infection, regardless of whether he is a member of the family of the deceased or not. If the widow is too young and not educated as to the correct use of condoms, there is a serious risk of new partners being infected.

3.5 Post-birth sexual Taboos

Traditionally, almost all Ethno-linguistic group in Angola have some taboos concerning breast-feeding, post-birth abstinence and other specific rites and circumstances. According to Redinha (1974) and Altuna (1993) abstinence is commonly practised during hunting, harvest, etc. These taboos, despite the interruption of births, contribute to extra-marital sexual relations and even in polygamous families when the abstinence periods are relatively long.

3.6 Woman Status

The concept of “status” is very complex. Some authors define it as the capacity to take individual decisions and to have access and control of resources. Others define it as the position each individual occupies in the society. Status is also associated with the roles, that is to say, individual contributions to productivity, regarding gender. Productivity is understood here as procreation as well as economic activity.

In Angola, the status of woman is basically determined by her fertility and ability to procreate which constitutes the main objective of marriage. Due to this importance, female sterility is one of the reasons used to justify male extra-marital practices and polygamy.

The underprivileged situation of woman in our society has led to a lack of education, economic dependence and consequently, restricted or no access to information, particularly on health issues. This fact influences on their sexual behaviour and then contributes to the spread of HIV/AIDS.

Conclusions

Individual behaviours depend mainly on socio-cultural context. However, certain behaviours and practices, that are culturally imposed, jeopardise sanitary conditions. In the concrete case of HIV/AIDS, some practices might contribute to the spread of the disease throughout the population. The knowledge of such behaviour and practices is extremely important in order to elaborate realistic and pertinent intervention strategies.

PART 5 : CASE STUDY

1. Introduction

After having presented a theoretical socio-economic and cultural approach to HIV/AIDS, we will finally present a case study in which we look into the knowledge of traditional norms, values and beliefs of the Angolan population, concerning sexuality, that could facilitate the HIV/AIDS spread.

We will also touch on issues related to behavioural changes caused by the disease and to solidarity towards AIDS patients during the current socio-economic crisis.

2. Methodology

2.1 Election of the Study Methodology

Demographic research carried out in developing countries has been based on methods that privilege quantitative analysis. These studies cover social behaviour and contribute to the elaboration and implementation of sanitary programmes. However, the “performance” of those methods is very limited in so far as they do not allow the comparison between different socio-cultural contexts. Likewise, the quantitative data gathered by the KAP studies does not refer to the elaboration of programmes that aim at people's behaviour changes.

This explains why qualitative methods have been intensified in the last years. Quantitative methods offer information that allows for optimum knowledge and understanding of specific social problems. Therefore, when the objective of a study is the elaboration of educational programmes, it is sine qua non well-developed information on socio-cultural environments, once certain behaviours are culturally established.

In this study, a focus group was chosen, this is a widespread qualitative technique. This consists of a group workshop that allows for a deeper understanding of the basic issues of any social phenomenon. The success of this technique depends, in part, on how qualified and experienced the group leaders are in running the discussions.

This technique was opted for because it offers valuable insights from a relatively small group discussion. In the same way, we were able to observe and acquire first hand knowledge about behaviours, attitudes, language and perceptions from participants. Such knowledge is important for the elaboration and implementation of programmes. Finally this technique allows for results to be obtained in a short time and with scarce resources.

2.2 Target Group

We planned to conduct four focus groups divided into two age groups: young and elders. We wanted to compare the practices and ideas of two generations with relatively different economic and socio-cultural backgrounds. However, due to financial constraints and strict time limits we only worked with the youth, in particular with students since they seemed to be more readily available.

2.3 Criteria to Select Participants

The used criteria to select the schools from where to draw students took into account the facilities to contact staff and whether the school could collaborate in the mobilisation of the students. It was difficult to mobilise students because the focus group workshops coincided with an exam period.

We mobilised secondary school and university¹⁸ students, namely from the Instituto Médio de Telecomunicações de Luanda and the Faculty of Medicine. The criteria to select students were the following:

- Be between 15-35 years old;
- Originate from one of the main Angolan Ethno-linguistic groups;
- Have some knowledge upon cultural norms, believes, traditions and practices of the group they belong to.

2.4 Groups and Participants Features

The two groups consisted of ten young participants, mainly single, including representatives of both sexes. The average age among secondary students oscillated between 16 and 23 years old, while the university students, between 23-35 years old.

There were representatives from the following Ethno-linguistic groups: Umbundo, Kimbundo, Kikongo, Lunda-Tchokwe and Nhaneka-Humbe.

2.5 Data Gathering

The animator used a questionnaire to gather data and to guide the discussion among the participants. This questionnaire was elaborated according to the objectives of this study. Data was gathered through a flexible manner so that some questions could be immediately modified in order to obtain supplementary information or to deepen a particular issue. This procedure assured that all answers corresponded to the objectives of the study.

¹⁸ We selected these specific educational levels because they cover the age group required for this study.

We aimed to obtain information on the following aspects:

- Knowledge about the traditional norms and practices regarding sexuality, namely the rites initiation of children and teenager's.
- Knowledge about HIV/AIDS transmission and prevention.
- Traditional and modern practices that are accepted and encourage the spread of STDs and particularly HIV/AIDS.
- Behaviour change due to new diseases, particularly, AIDS.
- Family and community solidarity towards HIV/AIDS patients.

These aspects guided the elaboration of the questionnaire (find enclosed).

2.6 Organisation of Workshops

The workshop's schedule and location, as well as the animator and reporter roles were determined previously. Each session lasted, uninterruptedly, approximately 90 minutes. The sessions were tape-recorded and extra notes drawn up. During each session, the animator made an effort to guarantee the participation of all members of the group, avoiding any judgement or comment on the content of their answers. The anonymity of all participants was guaranteed.

The animator's role was not to dominate the session but to deepen the subject-matter, which was drawn upon from a general idea towards the most specific issues. The discussions were flexible whenever there was a need to deepen a specific subject. All members of the group were motivated to participate equally in the discussion. At the end of each session, the animator summed up the interventions and gave the participants the opportunity to confirm or modify it.

The duties of the reporters were to distribute identification badges, record the discussion, write reports and assist the animator in conducting the session.

We noticed that all students participated in the discussion. Some of them had more knowledge about traditional sexual behaviour and practices than others. It is important to highlight that those participants who belonged to the Ethno-linguistic group Kimbundo showed little knowledge of traditions concerning sexuality. On the other hand, Kikongo participants were prone to lead the discussions. However, the animator usually managed to avoid this tendency and balance group participation.

Although we have just conducted two focus groups, we could affirm that the data gathered is very valuable. Finally the participants asked for more conferences or similar activities dealing with AIDS issues, particularly the forms of HIV transmission and prevention, as well as ways to combat the disease.

3. Data Analysis and Discussion

Data gathering is a dynamic and evaluative part of the qualitative research process. It is important to carry out an analysis as soon as the data has been gathered. In this case it consisted of note codifications, the analysis of the obtained answers and the elaboration of the synthesis report of each session. The final paper was elaborated from the analysis of the content of each session. For an optimum organisation, we will present the results and respective comments written in italics within a frame.

1 Rites of Initiation

1.1 Knowledge about Rites of Puberty Initiation

The majority of the participants affirmed not to have knowledge about rites of puberty initiation. This lack of information was more evident among Kimbundo youth. This could be a result of the cultural assimilation process that has marked the city of Luanda.

Those who knew something about this practice had obtained the information through older people (relatives or not), broadcasting programs that tackle issues concerning traditional practices and habits from several regions of the country.

“I heard about these issues listening to the radio programme A Nossa Terra.”¹⁹

“There are many songs on the radio that talk about it and I ask my eldest folks for more information.”

“My parents comment on some of the traditions from their region.”

1.2 Target Group

Those who did know about rites of initiation affirmed that in some regions of the country, boys and girls were submitted to these rites. However, none of the students had participated in any of them. All boys declared that they were circumcised but outside the context of any rite of initiation. The majority had been circumcised following their parents’ decision, as it was a common practice in their original region. Circumcised friends influenced some of them. None of the girls had been submitted to any kind of rites.

¹⁹ Translator Note: “A Nossa Terra” means “Our Land”.

“I was circumcised at home by a nurse”

“I was circumcised when I was 12 years old because all my friends were circumcised.”

However, the fact that none of the participants had experienced it directly does not mean that these practices have been abandoned. The participants were born and brought up in urban areas where these practices have lost their social meaning. However, circumcision is still a current practice in several rural areas where it has a deep sacred value.

1.3 Common Age for Rites of Initiation

According to some of the participants, girls were submitted to rites of initiation just after their first menstruation and boys when they were around 15 years old. Regarding circumcision, the majority affirmed that it depends on each group, but it is often carried out either just after the birth or between 12-15 years old. According to Kimbundo participants, circumcision is currently done before five years old; the decision is taken by the parents and does not have any ritual meaning. Circumcision carried out after 10 years old is often a decision of the teenager and a result of the influence of his circumcised friends.

“I was circumcised when I was 2 years old because it is a practice in the region from where my family comes”.

1.4 Objectives of Rites of Initiation

Some participants had an obscure idea that initiation rites prepare the teenager for adulthood. Almost everybody affirmed that circumcision was a *“hygienic measure”*.

According to Altuna, the rite of initiation has a changing function and prepares the boy to fulfil his social duties. The initiation is no more than *“a school of knowledge and life which consists of three revelations: the sacred, death and sexuality. The initiated boy learns about this, takes responsibility of them and incorporates them into his new personality. The initiation prepares the adolescent or the young man for his role as an adult with social rights and duties. In this way, it acquires an effective educational value as well as structure the personality of the initiated for his entire life.”* (Altuna, 1993, p. 291)

1.5 Patterns of Rites' Practices

As we expected, few participants knew the forms in which these rites are practised. However, we were able to gather some opinions:

“I know that in Cabinda, girls stay in a house during several days where they learn everything to become a woman.”

“In Cabinda, in order to date or get married, girls are submitted to a rite called Tchicumbi, during a month, just after the first menstruation, around 14 years old. It is for preparing the girl to adulthood.”

“In (the province of) Uíge, it is also practised. When girls begin to menstruate, they are all subject to the rite and then become married after six months.”

Nowadays, such rites are being ignored in several regions of the country, above all, in urban areas. According to one young man from Cabinda (Kikongo), *“these rites are practised solely in the south of the province, but it does not have the same impact it used to”*. Some participants affirmed that this situation is a result of the weakness of traditional systems due to social, economic and cultural transformations. These problems have been exacerbated by the permanent war that Angolan society has faced.

1.6 Sanitary Advantages of these rites, particularly circumcision

Participants think that some practices are harmful, as we will see further on. Nevertheless, it is a common idea that circumcision is a good hygienic measure.

1.7 Sanitary Disadvantages

The young mentioned several disadvantages regarding STDs, particularly AIDS:

“During these rites, the boy might have sex with his aunt and if she has the disease he is infected”.

“In other regions and in Cape Verde, it's also the same, the fathers have to take the virginity of their daughters. If he has the disease...”.

“The cause of death is not always known; if the individual inherits the wife of his brother the disease will remain in the family.”

Concerning circumcision, they give their opinions:

“When it is carried out by people without knowledge, the penis can become defective.”

“It can also provoke infections”

“It allows the transmission of diseases like HIV/AIDS when non-sterilised material is used.”

Altuna (p. 282) points out that *“after the circumcision, the child abandons, along with the foreskin, the infancy and acts with a new personality in the following rites.”* Therefore, *“circumcision proves definitive and visibly his radical transformation into an adult, that is, sexually able to procreate.”* For this reason, within the ethno-linguistic groups in which circumcision is institutionalised, women reject having sex with uncircumcised men either from their group or not.

Circumcision and other rites of puberty prove that boys and girls are definitively either psychologically or ritually able to be married and take responsibility for their social roles as adults. Therefore, many ethno-linguistic groups require circumcision as an essential condition to marriage.

2. Knowledge about STDs, particularly HIV/AIDS

2.1 Sources of information on STDs

All participants knew about STDs including HIV/AIDS. The majority mentioned radio, specifically, Radio Luanda and Eclésia, and television as the main mass media which spread such information. Among the TV shows, the Quem Sabe, Sabe²⁰ was the most popular. Others mentioned school, conversations with friends or acquaintances. One university student mentioned another source: the lectures run by the family planning program at the health centres.

2.2 Most Frequent STDs among Youth

The secondary students mentioned gonorrhoea, syphilis and AIDS. There was a conceptual misunderstanding since some of them listed *esquentamento*, which is a term popularly used to designate gonorrhoea, as a different disease. University students added candidacies to this list.

²⁰ Translator Note: “Quem Sabe, Sabe” means “Who knows, does know.”

2.3 Knowledge about different forms of AIDS transmission

All participants agreed that AIDS is transmitted through sexual intercourse, blood transfusion, non-sterilised cutting objects, infected needles and syringes, from mother to babies. One participant mentioned the sharing of a tooth-brush by several people. Others mentioned transmission through kisses.

“There are people that wash their teeth until they are bleeding. If this person has the disease they could transmit it to another one who uses the same tooth-brush”.

“If people have small wounds in the mouth, it could facilitate the passage of the disease through the kiss”.

2.4 To avoid the STD spread, in particular AIDS

This question raised a lively discussion among the participants. There were divergent and some times radical opinions. Since the transmission of HIV in our country is mainly through heterosexual intercourse, all participants agreed that the use of condoms, above all in occasional sexual relations, is the best way to prevent the disease. However, since there is a refusal to use condoms, some of them thought that regular blood analysis could help people know whether they are infected or not.

Concerning other forms of transmission, namely through blood transmission, students affirmed that measures should be taken in order to institutionalise the testing of HIV/AIDS throughout the country, either at public or private centres. All people who are considered to be part of a high risk group should be tested regularly.

Students brought up a particular situation: Although some people acknowledge the fact they are HIV+ or AIDS patients, they continue to infect others. Here are some of the most illustrative suggestions regarding this topic:

“To have one sexual partner”.

“Every HIV+ person should be located in a place with no contact to other people. Many know that they have the disease, but do not take the preventive measures because they do not want to die alone.”

“Institutionalisation of identification cards with the results of blood analysis that should be shown before each relation”.

“Blood analysis in the beginning of a relationship”.

“Abolish Polygamy”.

2.5 Traditional Practices which could eventually contribute to the AIDS spread

We list some other practices mentioned:

- Learning about sex with or without rites of initiation: the traditional way to learn about sex also contributes to the spread of the disease since the “*adult teachers*” (men and women) could be infected without knowing it.
- Scars: Special attention was paid to the practice of scar-tattooing that in certain ethno-linguistic groups is similar to beauty marking. According to the participants, this practice could transmit the disease due to the use of infected cutting instruments;
- The practices of blood brotherhood in which two people exchange and drink each other’s blood as a symbol of mutual faithfulness. In general, it is a pact that two individuals or representatives from two groups consummate through a rite in which they exchange blood. The pact creates a brotherhood and a sacred and sound friendship that when betrayed demands punishment. In our country, kikongo young people change their blood during the rite of circumcision. Altuna (p. 122) highlights that “*after soaking a piece of manioc in the blood of their foreskins, they eat ‘the bread of the Brotherhood’*”.
- The circumcision (individual or collective): when it occurs as part of rites of initiation involves a young population. If the blade is infected, everybody runs the risk of infection.
- When the umbilical cord is cut out: the midwife might use infected cutting objects. However, and according to a participant (a kikongo girl), the traditional way to do it does not involve the use of cutting objects. “*They tie a not, then, stretch the cord from this not and it snaps straight away.*”
- Polygamy: some participants think that polygamy, practised in the traditional way, protects the man and his wives from STDs and AIDS. Others disagree with it, because man does not have a relation with all his women at the same time. He has “*acquired*” them a long the time and, in some cases, he becomes polygamous through the practice of a surrogate. The modern patterns of polygamy and, consequently, promiscuity, above all among couples that do not share the same house, contribute to the transmission of STDs, particularly, AIDS.
- For many girls the first sexual contact is with their fathers: it is a practice observed in few groups, but which could facilitate the transmission of AIDS.
- Traditional marriage within the same tribe: it is a way to protect the group.
- Traditional healing when cutting or sharp objects are used.
- The practice of surrogate and similar ones.

2.6 Practices of Modern Treatment subject to transmit AIDS:

Participants mention the following situations:

- Non-sterilised injection and other intravenous instruments. Traditionally population and health professionals prefer the intravenous treatment which is considered the most effective.
- Small surgery material that is not sterilised at private health centres, either those located in urban periphery areas and run by nurses or public health centres.
- The transfusion of infected blood.
- Gynaecology and obstetric consultation in which the same gloves and tools are used with many women.
- Surgical interventions.

3. Cultural, Religious and Social Norms and Values that Influence Sexual Behaviour

3.1 Knowledge about Norms

The participants know that in traditional societies there is a system of rules that regulates the sexual behaviour of youth. However, due to the influence of “*modernisation*”, these rules have been neglected. The following are opinions expressed by the participants:

3.1.1 Virginit

Today virginit does not have a particular social meaning. However it is still valued in some families, above all in the religious ones. According to some participants, in some regions of the country, there is a tradition that on the wedding night the couple sleeps on a white sheet in order to show the blood stains. The aunt, godmother or grandmother are then responsible for taking the sheet and showing it to the neighborhood. If the girl proves to be a virgin, the neighbours bring gifts to her. If not, her family must pay a fine to the husband’s family. In extreme cases, the marriage can be dissolved.

“Woman who did not marry as virgins would be stoned.”

“The boy or the girl could be killed”.

“When the daughter is not a virgin, the families are very disappointed because it is shameful”.

“They make a hole in the sheet and this is shameful for the family”.

“In Cabinda, if the girl happens to be pregnant, she or the boy have to dance in a specific place to apologise to the gods and avoid curses.”

Some justify the reason for the absence of a social value of pre-marital virginity as a result of influence of the mass media, namely radio and television. Regarding television, they mentioned soap-operas and certain movies that have a strong influence on them. On the other hand, there is greater freedom to talk about sex which it was not common before because of the severe family sexual education. Parents did not talk openly about these issues with their children.

In view of the changes that our society has gone through and according to a secondary school student, *“even when a girl wants to preserve herself, she could not because she is under pressure by her male and female friends and then she ends up having sex before the marriage.”*

Others said: *“It is always an honour for a man to marry a virgin woman, but nowadays it is not very common because virginity does not have a value anymore”.*

3.1.2 Beginning of Sexual Life

Within the traditional societies, the beginning of sexual life is very early, but it is regulated and reproduction oriented. In this way, the youth begins their sexual life within a framework of a formal union. Today, the practice of sex addresses pleasure, as well as the learning of sex addresses the duties of a husband.

3.1.3 Sex before Marriage

The fact that girls are forbidden to have sex before marriage was associated to the social value of virginity. Presently, this has been lost though, and the practice of sex before marriage or a formal union is no longer an immorality. The male participants affirmed that having sex is crucial since girls do not accept to marry men without some sexual experience. Girls gave the same justification.

“It is an honour for a man to marry a virgin woman, but it is not the same for women.”

“In general, women do not accept to marry a virgin man because they want experienced men. This behaviour compels boys to have sex to better carry out their mission as a husband.”

“Nowadays, young men do not want to be involved with virgin women; a friend told me that a virgin woman is very complicated, she can even faint on the bed and I do not want to be responsible for that.”

“In traditional marriages, boy and girl do not know each other; it is a family arrangement, hence, they could not have had sex before the wedding.”

Some affirmed that the loss of virginity is something that could happen even within a religious family. Some very conservative fathers “*end up disdaining their daughters*”.

3.1.4 Marital Faithfulness

The practice of marital faithfulness, based mainly on religious precepts, also influences sexual behaviour. Even with polygamy, men are limited to sexual relations with the women with they live with and vice-versa.

“Nowadays, the cases of unfaithfulness are very common taking into account the phenomenon called Catorzinhas”.

3.2 Following Norms

Participants agreed that in view of recent social changes observed in Angola, the number of people that follow those norms is almost insignificant, above all in urban areas. Regarding the groups most vulnerable to “*deviation*”, there was a controversy. Some female participants said that men are more prone to neglect the norms because they have political and economic power. Nevertheless, since traditionally men always had more sexual autonomy, this deviation is tolerated. It is not the same with women for Angolan society has always been chauvinistic.

“In the past, men diverted more than women, but today women are more vulnerable.”

“When poor, women are more vulnerable to prostitution”.

“Prostitution is in large part a result of economic difficulties, poverty, above all for those women are whose needs are not met by their salaries.”

“In Angola there is poverty and some girls use sex as a commercial object.”

“It is men with political and economic power that have created the phenomenon of Catorzinhas”.

“It is easier to stone a woman because she is found with a lover than a man.”

“Our society is still macho..., hence, male deviations from the norms are not considered immoral.”

At the present, due to social and economic difficulties in the country, the majority of young people understand that women are the most vulnerable group, taking into account that the increasing number of girls involved in open or hidden prostitution in big cities.

Some participants pointed out that there is also male prostitution, which is neither visible, nor spoken of in our society.

Despite the deterioration of traditional social norms regarding sexual behaviour, there are differences between what is socially acceptable to men and women. Hence, women are not allowed to have many partners at the same time or change regularly, husband or boyfriend, otherwise the society would look down on them. A secondary school girl eloquently commented:

“We are descendants of a culture in which men could have many wives, but women could not (have many husbands), because of this society does not look down on men.”

Concerning to how the society treats women who “*turn away from the norms*”, we select the following sentence:

“These girls are socially discriminated and considered as antiquated and antisocial. They are marginalised because people assume that they are drug users.”

Concerning the role of education, participants affirmed that despite the deterioration of cultural and religious values, education as a whole, in particular sexual education within the household, would be crucial in so far as youth would be warned as to the consequences of risky behaviour. However, parents not always give information that the youth needs to face the daily problems.

Some participants consider that the majority of Angolan families do not talk about sexuality either because sex is a taboo or because parents think that “*they would motivate their children to have sex*”. However, they acknowledge that mothers could be more “*open*” than fathers. Teenagers between 14-20 years old expressed the same opinion during the study on risky behaviours among adolescents carried out in Luanda (Leitão, Ana, 1997). Despite this openness, the topics discussed are very limited to menstruation and pregnancy in the case of girls. Thus, the young have to look for information outside of home running the risk of getting distorted information. Some of the participants claimed that “*school does not carry out its educational role either*”.

4. Solidarity towards patients, in particular, AIDS.

The results indicate that family solidarity happens in a similar pattern in rural and urban areas. However, it is more effective in rural areas. For example, if an adult is sick and he is an active member of the family, the others organise themselves to guarantee that his absence does not disturb the family income.

Traditionally, the family contributes financially in case of disease or death. Community solidarity depends on the relation among the neighbours and the type of aid could consist of participation in the treatment or work in the field.

In case of death, and if the deceased is a household leader, the wife can keep on living with his family through surrogate system that aims at protecting the widow and, specially, the children. Nevertheless, there are cases in which the family assumes that wives are guilty of the husband's death. Then they lose all inheritance rights and go back to their original home with their children.

When wives die, husbands can also continue to live with her family through the surrogate system.

Women (being wives, mothers or sisters) are traditionally responsible for sick people within the family as some female participants illustrate:

"I had to miss school and work to take care of my sick husband or son."

"Fathers are worried and disturbed, but do not help that much".

"There are boys who help, it depends on their education".

Regarding orphans, participants affirmed that, in most of the cases, grandparents (maternal or paternal) are "*obliged*" to take care of their grandchildren.

As regards the AIDS patients, the majority of participants said that their family and neighbours marginalise them because people know that the most common form of AIDS transmission is through heterosexual intercourse. According to a male participant, "*people look down on AIDS patient because they assume that this person got sick being promiscuous*". Another female student stressed: "*I had an uncle who died of AIDS. All the women ran away.*"

The rest of the students believe that the patient would receive the same support as with any other disease. However, the entire group agreed that the family support depends chiefly on the relationship between the sick person and the other members of the family.

The students did not have a clear idea on the issue of what should happen to the widows and their children. Some affirmed that all would depend on the acceptance of the sick person by the family, while others said that it would depend on the friendship between the patient and the family.

None of the participants knew about the rites practised in the case of deaths caused by the disease.

Indeed, the AIDS patient affects the household and demands solidarity from a family that has already been affected by the economic crisis. The solidarity towards AIDS patients means economic aid to ensure medical care, medicines, and psychological and social assistance. Due to different reasons, solidarity is not always effective because of economic and social hardships, especially among more underprivileged families.

The diagnosis constitutes an important issue for family relations. The doctor often informs the sick person who in turn decides to whom among the family he will inform his situation. However, most people prefer to keep a secret for many reasons. The participants asserted that the AIDS patient is afraid of being rejected because this disease is commonly associated to unfaithfulness, promiscuity and prostitution.

The lack of knowledge about the origins of disease, such as the forms of AIDS transmission, creates attitudes and fears that are detrimental to family relations, leading the sick person to hopelessness and all consequences: rupture with the family, rejection, neglect, etc. On the other hand, family reaction is, overall, conditioned by familiarity with the disease, the socio-economic level, the degree of understanding on forms of AIDS transmission and so on.

The economic support of AIDS orphans is another serious issue. When both parents die, grandparents are often responsible for the children. It causes difficult situations since the grandparents are old and need financial support to look after the children.

5. Behavioural Changes in view of the AIDS Epidemic

According to the majority of the participants, behavioural changes are not very visible despite the activities conducted by the National AIDS Combat Programme. Some focused on the case of prostitutes that have been “*blackmailed*” by their customers who are not informed nor sympathise with preventive measures. These oblige prostitutes to have unprotected sex.

The same regretful attitude can be observed at private and public health institutions where the neglect of bio-security norms constitutes a daily practice. The students focused on the fact that, even in Luanda, there are blood transfusions without any control.

Some of the female participants believe that traditional practices such as the surrogate, the teaching of sex as part of the rites of initiation and so on have been questioned by less conservative social groups, since these practices could spread the disease within households and communities.

To exemplify the reluctance to the change risky behaviours, in particular regarding the use of condoms, we mention the following:

“Some people say that AIDS does not exist.”

“Others say that AIDS was made up to break the passion of lovers”.

On the other side, most of the youth believes that health education activities conducted by the NACP do not even reach 25% of its target group. Hence, they suggest the execution of lectures at schools and other places frequented by young population.

Regarding condoms, despite the knowledge of their usefulness in preventing HIV/AIDS prevention, condoms are hardly used. Boys and girls asserted that *“only use them in occasional sexual relations that they consider risky”* and *“when they want to avoid pregnancy”*. The criteria to define an occasional sexual relation as risky or not is often subjective. Therefore, young people could expose themselves to infection due to misjudgement. Male participants reject using condoms because they consider that condoms reduce sexual pleasure and are painful. The female participants said that even when they suggest that their partners use of condoms, they are often faced with argument the following:

“They say they like to feel skin on skin”.

“Taking a shower and going outside (dressed) in the rain are two different things.”

“When emotion hits there is no room to condoms”.

On the other hand, some girls justify the low use *“due to the fear that the condom could remain in the vagina”*, because according to them, *“surgery would be necessary to take it out”*. This fear was mentioned by some of the secondary school female students.

Others asserted that the prices of the condoms are too high for the majority of them. Besides that, there is no information regarding the places where the condoms are sold.

Some participants believed that the promotion of the use of condoms among the youth would indirectly motivate the *“irresponsible”* practice of sex once the condom is also used as a contraceptive.

Taking into account the age and level of education of the participants, we assumed that the use of condoms would be more effective and accepted. The answers clearly show the gap between being informed and daily practices, as well as the cultural pressure on individual behaviours.

Finally, we could affirm that the results of this case study confirm the hypothesis asserting that certain socio-cultural practices, particularly regarding sexuality, could seriously

obstruct the prevention campaigns of and fight against HIV/AIDS. This situation is beyond the intervention of health professionals.

Conclusions

The education and awareness programmes regarding HIV/AIDS and the use of condoms implemented in the country so far have not produced the desired results yet. The main reason for this failure lies in the distortion of educational methods and awareness of the subject-matter. Both ignore the importance of socio-cultural norms and values regarding sexuality.

Despite the concentration of health, social and economic infra-structures (schools, mass media, health centres, etc.) in urban areas, a substantial part of its population does not have precise information on HIV/AIDS transmission and prevention. In addition, education on the health programmes elaborated has not yet taken into account the true importance of socio-cultural norms and values regarding sexuality.

Successful AIDS prevention in Angola depends on the execution of studies based on social science. The main objective should be the diffusion of information about the evolution of key issues that consider the sexual behaviour of the population and its relationship with the transmission of the disease.

Considering that the disease does not yet have a cure, Information, Education and Communication activities constitute the strong points in the prevention of HIV/AIDS. These activities are not only up to the Ministry of Health; they also demand the participation of other national sectors.

Recommendations

We propose the following recommendations:

- Promote studies to deepen the knowledge upon socio-cultural and economic factors that determine the sexual behaviour and take these factors into account in the management of the programme for prevention and combat AIDS.
- Amplify IEC activities among the population, in particular, the most vulnerable groups to the spread of the disease.
- Identify the specific needs of these groups and develop methods of intervention so as to design social and culturally acceptable solutions. The messages must be specific and adapted to the type of language appropriate to each group. Consequently, they will exert a greater influence on these groups and lead to effective behavioural changes.
- Elaborate messages adapted to the attitudes of the young might lead this sector of population to modify its behaviour. As they are the future of the country, they should be mobilised and actively involved in the search of solutions in order to overcome the social obstacles to the prevention of AIDS. Once the laws regarding sexuality and the rights of

youth are reviewed the preventive actions will become more effective. We thus recommend the adoption of a legislation on moral and civic behaviours.

- Mobilise and educate prostitutes to promote, distribution and utilisation of condoms.
- Create a supra and multi-sectoral organism, as part of the highly hierarchic manner in which the state will conduct policies and guarantee that all sectors (public, private, NGOs) will own the authority and necessary resources to implement activities of prevention and combat AIDS.
- Co-ordinate activities together with Radio Ngola Yetu in order to divulge information on AIDS in the different national languages, focusing on the traditional practices that could facilitate the transmission of the disease.
- Educate families about the risks, as well as safe and responsible sexual behaviours.
- Be aware and educate the communities to expand their activities of HIV/AIDS prevention and care to all their members, along with the creation of an adequate social context in which people who have contracted HIV/AIDS are not discriminated against.

ANNEXE 1 : Governmental Partners in the Fight Against AIDS

International Partners and MINHE/United Nations

Institutions	Support
WHO	Support for management, administration, Epidemiological Vigilance, IEC, Laboratory Support (1993); Seminars on Bio-Security and asepsis; Diagnosis and treatment of STDs for nurses from SMI/PF; Data bank for AIDS reported cases and epidemiological vigilance, Project APV - Public discussions, Financial support to HIV+ persons through the NGO APV; Support to NACP Provincial Centres; Monitoring provinces; Seminar on management for seven provinces; National seminar on epidemiological vigilance; Seminar on STD.
UNAIDS	Advocacy; Resource mobilisation, Profile analysis of the country in view of STD/HIV/AIDS; Technical Support for the development of projects carried out in areas regarding vigilance of epidemics; STD; Support to refugees; Support to PWAs.
UNFPA	Reproduction of a manual on STD/AIDS Education elaborated by ELSIDA; Creation of the Centre for Adolescents Support (education and communication activities, lectures in schools and communities); Fund for a seminar on Adolescence in Angola; Fund for training courses through the Health School Programme for 160 primary school teachers in 5 provinces; Fund for a manual on sexual education for schools that work jointly with UNFPA.
UNICEF	Fund for APV, Project Street Children - STD prevention; Co-fund with UNFPA for training courses through Health School Programme for 106 primary school teachers from 5 provinces; Fund for a manual on sexual education for schools that work jointly with UNFPA; Fund for a KAP study in Luanda in 1994 - involving 1069 young people.
UNDP	Advocacy to support UNAIDS activities. Interaction of 6 agencies co-responsible for UNAIDS; Creation of the Joint Support System with the UN agencies; Management of UNAIDS funds.
WORLD BANK	Fund for KAP studies in Luanda and Huíla (1995 and 1997); acquisition of condoms; IEC; International technical assistance in epidemiological vigilance; counselling; technical support for the elaboration (of) norms; Training in the areas of IEC evaluation: epidemiology and training in computer skills.

International Partners and MINHE/ Bilateral and Multilateral Agencies

Institutions	Support
ASDI	Support to National Blood Centre, sampling and quality control; Acquisition of 3.000.000 condoms; Support for the NGO - ELSIDA in IEC; Preparation of trainers; Financial support to AALSIDA; Project Call Service; Fund to APV, Project Bispo Beach Service (street children Literacy); Health education for teenagers through UNFPA.
FRENCH CO-OPERATION	Training of national technicians in the clinical diagnosis of STDs; Acquisition of sterilisation material for hospitals; Counselling for HIV+ persons and AIDS patients at the Josina Machel Hospital; Creation of the STDs Treatment Programme in consultations PF; Fund for the Project Kanasida (for commercial sex workers) NGO-APV.
NORAD	Development of medium-term plans; Reinforcement of the ability to analyse epidemiological data.
CANADA	Participation in international conferences on AIDS; Support for ELSIDA
ITALIAN CO-OPERATION	Fund for a seminar on the Microbiology of opportunist STDs; Technical and material support to implement the epidemiological vigilance survey; Technical and financial support for the Epidemiologic Vigilance Programme to be implemented jointly with CIRPS technical support; Fund in collaboration with WHO for the manual of counselling on STDs and AIDS for displaced soldiers.
EUROPEAN UNION	Support for the Project Transfusion Security; Fund for the Project Education for Health with community participation in the Province of Bengo.
Medicus Mundi Spain	Technical Support in the implementation of 6 laboratories in 1991 and 4 in 1992 to sample HIV through rapid tests. This was financially supported by the European Union.

International Partners and MINHE/International NGOs and Private Enterprises

Institutions	Support
Cabinda Gulf	Fund for the survey of HIV prevalence in pregnant women; Seminar on STD; STD diagnosis and treatment; Support of HIV/HBs/VDRL sampling at the Haemotherapy Centre; disposal of material; medical and surgery equipment; Clinical and therapeutic support for STD/HIV/AIDS patients.
Caritas	IEC for secondary school students in Luanda; Clothing and medicines for HIV+people and AIDS patients through NGO-ALSIDA.
Norwegian Popular Aid	Food and clothing for HIV+ people and AIDS patients through the NGO-ALSIDA.
World Lutheran Foundation	Food and clothing aid for counselling activities.
NESTLÉ	Informative monthly newsletter “Dialogando sobre o HIV/SIDA” to be published from October 1997; IEC Activity on STD/HIV/AIDS
OFXAM MAP International Africa	Fund for equipment and salaries of NGO-ALSIDA, counselling and support for HIV+people and AIDS patients; Training religious community leaders in counselling and assistance for HIV+people and AIDS patients in the city of Luanda (started in November 1997); Work collaboratively with NGO-Acção das Igrejas em Angola.

ANNEXE 2 : Angolan Ethno-Linguistic Groups and Sub-groups

BANTU GROUP

Quikongo Group

Vili

Iombe

Cakongo

Oio

Sorongo

Muchicongo

Sosso

Congo

Zombo

Iaca

Suco

Pombo

Luango

Guenze

Paca

Coje

Bata

Sundi

Quimbundo Group

Ambundo

Luanda

Hungo

Luango

Ntemo

Puna

Bembo

Ngola or Jinga

Bondo

Bangala

Cari

Chinje

Minungo

Songo

Bambeiro

Quissama

Libolo

Quibala

Haco

Sende

Ovimbundo Group

Bieno

Bailundo

Sele

Sumbe or Pinda

Mbui

Quissanje

Lumbo

Dombe

Hanha

Ganda

Huambo

Sambo

Caconda

Chicama

Quiaca

Galangue

Lunda-Tchokwe Group

Lunda

Lunda-lua-Chinde

Lunda-Ndembo

Quioco

Mataba

Bandinga or Cacongo

Herero Group

Dimba

Chimba

Chavicua

Cuanhoca

Cuvale

Guendelengo

AmbóGroup

Vale

Cafima

Cuanhama

Cuamato

Dombondola

Cuanger

Ganguela Group

Luimbe
Lwena
Lovale
Lutchaz
Bunda
Ganguela
Ambuela
Ambuela-Mambumba
Engonjeiro
Ngoniolo
Mbande
Cangala
Iahuma
Luio
Ncoia
Camachi
Ndungo
Nhengo
Nhemba
Avico

Nhaneka-humbe Group

Muila
Gambo
Humbe
Donguena
Hinga
Cancua
Handa (Mupa)
Handa (Quipungo)
Quipungo
Quilengue-Huembe
Quilengue-Muso

Xindonga Group

Cusso
Dilico
Sambio
Maxico

NON-BANTU GROUP

Hogentote-Bushman

Yellow Bushmen: Mucuancalas and Cassequeles

Black Bushmen: Vazamas and Cazamos.

PRE-BANTU GROUP

Vátua: Cuissis and Cuepe

ANNEXE 3 : Survey Guide

1- Rites of Initiation:

- Have you ever heard of rites of initiation?
- Where did you hear about them?
- Who is submitted to these rites?
- At what age are they subjected to these rites?
- What are the objectives?
- How are they practised?
- What health advantages do they represent?
- What about the disadvantages?
- Have you been subject to one of these rites?

2- Knowledge of STDs, in particular HIV/AIDS:

- Have you ever heard about STDs?
- Where did you hear about them?
- How is AIDS transmitted?
- Which are the most common diseases among the young?
- What can be done to prevent the spread of STDs, particularly, AIDS?
- Do you know of any traditional practices that could eventually contribute to the spread of STDs and HIV?
- Do you know of any modern medical treatment that could transmit AIDS?

3- Cultural, Religious and Social Norms and Rules that influence sexual behaviour:

- What are people's attitudes towards past practices such as pre-marital virginity, monogamy/polygamy, sexual education for the young, the first sexual experiences (the difference between boys and girls), sexual relations before the marriage? And how are these practices seen nowadays?
- How could traditional norms help in preventing the spread of STDs and AIDS?
- What norms might encourage the spread of STDs and AIDS?
- Differences between acceptable sexual behaviours for men and women.
- Do all people follow these norms? Who does not? How are these people seen socially?
- Do you talk about sexuality with your parents?
- Which specific subjects are tackled?

4- Solidarity towards AIDS patients

- When somebody is sick at home, how do the other members of the family organise themselves?
- How do other members of the community face the situation?
- What kind of support is offered (in rural and urban areas)?
- Who are most often responsible for taking care of sick people at home?
- If an adult member of the family dies, who takes care of his wife(s) and his children?
- If somebody at home has AIDS, how would he/she be seen by family and neighbours?
- Would he/she have the same support as though it were any other disease?
- What would happen to a man's wife and children in case of his death from the illness?
- Are there rites concerning AIDS?

5- Behavioural changes in view of the new diseases:

- How have sexual behaviours changed due to new diseases, in particular, AIDS?
- Do you know what a condom is?
- Do boys use condoms when they have casual sex?
- If not, explain.
- And girls, do they suggest that boys to use condoms?
- Do they accept it?
- If not, explain.

ANNEXE 4 : Survey Guide 2

Survey Guide

1- Knowledge of STDs, namely HIV/AIDS:

- Have you ever heard about STDs?
- Where did you hear about it?
- What do you know about such diseases (transmission, prevention, treatment, possible complications)?
- What consequences could it cause to the couple and/or family?

2- Attitudes towards STD/HIV/AIDS patients:

- Do you know somebody who has had these diseases (among relatives, friends, etc.)?
- If yes, how did you react? If not, How would you react?
- If your partner had been infected, how would you react?
- Do you know that you could keep on living as a couple? Would you keep on having sex using condoms?

3- Individual availability to participate in community actions to prevent and combat HIV/AIDS:

- If you were invited to participate in a volunteer group to support activities of HIV/AIDS prevention and combat, would you accept it?
- If yes, how would you contribute to reduce the transmission of the disease?
- Would you accept to participate in a youth counseling group on sexuality?

ANNEXE 5 :
Supplement to the Study on Socio-cultural Approach to AIDS in Angola

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Luanda, April 1999

Introduction

After identifying the main socio-cultural characteristics of the Angolan people and reflecting on their attitudes, beliefs and practices concerning sexual practices, we now intend to assess the level of individual motivation of individuals in the prevention of STDs, in particular, HIV/AIDS. This study will also address AIDS prevention and combat carried out by this population taking into account the current socio-economic and cultural framework prevailing in the country.

In this way, we hope to obtain worthwhile information that could assist decision-makers at the health and education levels in the design of action plans to prevent STD and, particularly HIV/AIDS.

Hence, this chapter aims at the following:

Main Objective

Assess the degree of individual motivation or initiative to participate in community actions to prevent STDs, in particular HIV/AIDS, to reduce its spread throughout the family and community.

Specific Objectives

Assess the level of knowledge about STDs and above all HIV/AIDS.

Identify the individual perception towards the necessary measures to prevent the spread of these diseases among the community.

Identify the level of individual and family motivation and commitment to IEC activities regarding sexuality.

Methodology

As mentioned in the previous work, the qualitative method is the most indicated for studies that intend to study or assess knowledge, attitudes and practices in order to design programmes for behavioural patterns to change.

According to the objectives of this chapter, we elaborated a survey with open questions (find enclosed) and carried out individual interviews with men and women over 50 years old, of different ethno-linguistic groups. They have knowledge of traditions, beliefs, habits and practices regarding sexuality in their respective communities. We considered these four people to be “*key persons*”.

The interviews were recorded, having been conducted in an environment that respected the privacy, confidentiality and, above all, the opinions of the respondents.

Next we will present a synthesis of the answers. In order to gain a better systematization, results will be presented according to the three major issues that guided the questionnaire used during the interviews.²¹

Analysis and Discussion of Results

1- Knowledge about STDs, namely HIV/AIDS

All respondents had known of the existence of some sexually transmitted diseases in their communities since early on in their lives. Likewise, they mentioned that HIV/AIDS is a recent disease.

Three of them affirmed to have heard about this disease through media, radio and television, while one interviewee mentioned the hospital.

“I heard about it in Benguela, at the hospital.”

“I have already heard about it around and on television.”

“I heard of it on the radio”.

All respondents mentioned that HIV/AIDS is transmitted through sexual intercourse. According to one of them, “*if somebody has the disease, it is soon assumed that this person has had sex with A or B.*”

They affirmed that STDs are more common among “*peessoas da vida*” (prostitutes). According to them, married women (or in concubinage) are infected by husbands that have sex with “*as tais da vida*”. Only one respondent mentioned other ways: “*it is transmitted through sexual intercourse, used syringes, blood transfusion, etc.*”

It is important to highlight that all respondents, regardless of their gender, believe that, formerly, men were mainly responsible for the spread of STDs between a couple or in the community because they had sex with prostitutes. However, today, they are aware that today there is a greater sexual autonomy among the youth, which changes the

²¹ We used the same method of analysis which is explained in the main paper.

patterns of HIV/AIDS transmission. Therefore, they understand that “*nowadays, both men and women could transmit the disease*” within the community.

“The man is the one who passes the disease to the woman.”

“There was a woman's disease called ‘esquentamento’; but men who slept around were infected by prostitutes and brought it home.”

“I know that the husband passes things on to the wife”.

“The wife also can pass an illness on to the husband...”

The respondents did not know of traditional forms to prevent the disease. Few had heard about condoms. For example, one female respondent affirmed: “*the husband does not say where he goes around and if the woman asks, he hits her; whenever the man sleeps away from home, the woman better watch out. She should buy wood at the market - muxi ua kipaulu²² - and put it all over her body*”. Nevertheless, she doubted its efficacy in the prevention of disease, above all HIV/AIDS. A male respondent pointed out, “*I do not know the traditional way to heal these diseases, but in Malanga there are many roots to heal diseases*”.

Another female respondent stressed that the most effective way to avoid the spread of the disease is to talk with the husband and “*make him aware toward the danger of these diseases or, if before the marriage she finds out that the man has had sex with prostitutes, she must not marry him.*”

Concerning the consequences, the respondents mentioned the spread of the disease among people (couple and community): “*...if (the diseases) are not completely healed, one can pass it on to the other*”. They also commented on the death of infected individuals, that leads to family instability, the loss of labour force in the community, etc.; issues that have been extensively discussed in the first part of this paper.

2- Attitudes towards STD/HIV/AIDS patients

All respondents know someone who has already been infected by an STDs. Some know relatives and friends who have recently died of AIDS.

“... Of Aids just now because two persons in the family died; a cousin, the husband got the disease in Portugal and passed it on to his two wives...”

“I know about a friend who died of AIDS.”

²² Translator Note: This stick is traditionally used by women to prevent certain diseases.

Concerning their reactions (to STD patients), they confessed to be hurt, particularly in case of the people that were infected with HIV/AIDS. They stressed that the impact is bigger because the majority of people “get the disease because they are promiscuous”. That sexual intercourse is the most known form of HIV transmission among them could justify that reaction.

The male respondents reacted angrily to questions concerning the possibility of their partners being infected. It was said that they would throw out their partners. On the contrary, women seemed to be more resigned to the situation. According to them, they would not reject the partner, but they would no longer have sexual relations with him. This difference in their attitudes is probably a result of the fact that women are still submissive to their husbands. Now, we present some of their comments that illustrate these attitudes.

*“If the doctor says that **he** has caught the disease, the woman would be upset... and very distressed, but she would take care of him...”*

“If my brother has the disease, despite my anger I would take care of him; if it is my wife who gets the disease, she has to go away...”

“... I would punch her and throw her out of the home. Life as a couple would be over...”

“... We would become friends, I could do everything (cook, laundry,...) but I would not trust him as a wife anymore.”

“...It is one more disease, I would not disdain him...”

The use of condoms was neglected by the respondents since they do not acknowledge the utility of condoms for HIV/AIDS prevention and combat. Along with this, sexual relationships are traditionally associated with reproduction and therefore condoms are considered contraceptives.

3- Individual Availability to Participate of Community Actions to Prevent and Combat HIV/AIDS

The respondents seemed willing to participate in support groups to prevent and combat HIV/AIDS, as well as to support families with AIDS patients. However, this availability could be jeopardised due to the socio-economic difficulties that these people face.

“As a religious woman, I would accept the AIDS patient because it would be as though this person had anyother disease.”

“...If the person is healthy, I accept...”

“... I would accept because the situation is very sad; poverty leads the girls to look for money sleeping around; I would accept because it is humanitarian work, but it would depend on the time that I had available...”

Their contribution could be mainly through the youth counselling encourage young people to maintain responsible sexual behaviour. One of the respondents highlighted, *“to advise them to stop sleeping around with prostitutes”*. The respondents suggested that there should be community work to explain to people how to prevent the disease.

Although respondents were willing to participate of HIV/AIDS prevention and combat, they confessed that they would not be comfortable talking about sexuality with the young. The comment of one the female respondents clearly reveals their constraints in tackling this type of subject:

“It would be a little difficult because the upbringing that we had was very different and I would not feel comfortable talking about this subject; I do not feel like speaking about these issues. For example, in the past, if we had lost our virginity before our wedding or if we were pregnant, we would talk to an aunt, but a friend aunt, who later on would tell our mother. The mother did not speak directly with us because she thought that if she talked openly with us, she would be encouraging us to become prostitutes. Or the daughter would be more promiscuous and would not respect the mother.”

Conclusions

The results of the interviews could not be generalised since they reflect the opinion of a very reduced number of people, though we consider them *“key persons”*. Hence, we suggest the execution of a more representative study in order to bring to light crucial issues for community strategies to prevent and fight HIV/AIDS.

Evidently respondents have a vague knowledge of the different forms of HIV transmission and prevention. They seemed to be willing to participate in community activities to prevent and combat AIDS despite the arduous socio-economic situation that has affected the country for several years. We strongly believe that, despite the current circumstances, the community could offer traditional resources and support of activities for the prevention and combat of HIV/AIDS.

BIBLIOGRAPHY

- ALTUNA, P. Raúl (1993), *Cultura Tradicional Banto*, 2nd edition, Luanda, Secretariado Arquidiocesano Pastoral, 622p.
- AMADO F., CRUZ F., HAKKERT R. (1992), “Urbanização e Desurbanização em Angola” in: *Cadernos de População e Desenvolvimento*, Luanda, vol. 1, nº 1, Jan-Jun, p. 57-92.
- ANGOLA, INSTITUTO NACIONAL DE ESTATÍSTICA (1992), *Inquérito sobre o Emprego e Desemprego na Cidade de Luanda*, INE/SEPLAN, Luanda, 282 p.
- ANGOLA, INSTITUTO NACIONAL DE ESTATÍSTICA (1996), *Inquérito Socio-demográfico à População Deslocada*, Luanda, Gabinete de Monitorizaçãp das Condições de Vida da População, 78p. (42 p. texto, 36 p. annexes)
- ANGOLA, INSTITUTO NACIONAL DE ESTATÍSTICA (1996), *Perfil da Pobreza em Angola*, Luanda, Gabinete de Monitorização das Condições de Vida da População, 97p.
- ANGOLA, MINISTÉRIO DA SAÚDE (1990), *Relatório de Actividades do Departamento de SMI/PF*, MINSA, Luanda.
- ANGOLA, MISTÉRIO DA SAÚDE (1997), *Relatório do I Semestre de 1997 do Programa Nacional de Luta contra o SIDA*, MINSA, Luanda.
- ANGOLA, NÚCLEO DE ESTUDO DA POPULAÇÃO (1995), “A População Angolana e suas Características Socio-demográficas” in: *Cadernos de População e Desenvolvimento*, Luanda, April/May, 126 p.
- ANTOINE, Philipe and Agnès Guillaume (1986), “Une Expression de la Solidarité Familiale à Abdjan: Enfants du Couple et Enfants confiés, *Les familles d’aujourd’hui: Démographie et Évolution Récent des Comportements Familiaux*, Colloque de Genève (17-20 September 1984), nº 2, Paris, AIDELF, p. 289-297.
- CALDWELL, John e al. (1993), “African Families and AIDS: Context, Reactions and Potential Interventions”, *Health Transition Review*, Sexual Networking and HIV/AIDS in West Africa, vol. 3, p. 1-16.
- CALDWELL, John C. and Pat CALDWELL (1983), “The Demographic Evidence for Incidence and Cause of Abnormally low Fertility in Tropical Africa”, *World Health Quartely*, vol. 36, nº 1, p. 2-34.

- CARAËL, Michael and Peter PIOT (1989), “Le SIDA en Afrique: Aspects Epidemiologiques et Sociaux” in: Gilles PISON, Etienne vand Walle, Mpembele SALA-DIAKANDA (ed.), *Mortalite et Societe en Afrique*, p. 385-397.
- COSTA, J. Leite (1995), “Mulher e o SIDA” in: *Saúde em Angola*, Boletim Trimestral da OMS, nº 2, Luanda, p. 14-15.
- DELCROIX, Sykvue and Agnés GUILLAUME (1997), “Le Devenir des Familles Affectées par le SIDA: Une étude de cas en Côte D’Ivoire in: *Ménages et Familles en Afrique*, Paris, Collection Les Études du CEPED, nº 15, p. 345-369.
- DOZON, Jean-Paul and Agnés GUILLAUME (1994), “Contextes, Conséquences Socio-Économiques et Coûrts du SIDA” in: Jacques VALLIN (ed.), *Population Africaines et SIDA*, Paris, collection Recherche, La Decouverte, CEPED, p. 179-223.
- FNUAP (1997), *A Situação da População Mundial*, New York.
- LEITÃO, Ana, Isilda NEVES, and Filomena WILSON (1997), *Saúde dos Adolescentes - Comportamentos de Risco*, Luanda, MINSA/ASDI/FNUAP, 49 p. (+56 p. annexes).
- MOURA, H. (1992), “O Factor Demográfico e a Planificação do Desenvolvimento” in: *Cadernos de População e Desenvolvimento*, Luanda, vo. 1, nº 1, Jan-Jun, p. 155-161.
- ONUSIDA (1997), DTS/HIV/SIDA. Perfil do País e Resposta Nacional, Luanda, ONUSIDA/PNLS, 43 p.
- OPPONG, Christine (1988), “Les Femmes Africaines: des Épouses, des Mères et des Travailleuses, in: Dominique TABUTIN (ed.), *Population et Societé en Afrique au Sud du Sahara*, Paris, L’Harmattan, p. 421-436.
- ORGANIZAÇÃO MUNDIAL DA SAÚDE (1994), *Saúde em Angola: Ponto de Situação*, Luanda, OMS, 155 p.
- ORGANISATION MONDIALE DE LA SANTE (1989), *La Santé des Méres et des Enfants dans le contexte de l’Inféction à VIH/SIDA*, Paris.
- PISON, Gilles (1988), “Polygamie, Fécondité et Structures Familiales” in: Dominique TABUTIN, (ed.), *Population et Societé en Afrique au Sud du Sahara*, Paris, L’Harmattan, p. 249-278.
- PNUD (1997), *Human Development Report, Angola 1997*, Luanda, 125 p.
- REDINHA, José (1974?), *Etnias e Cultura de Angola*, Luanda, Actualidade Editora.

ROBERT, Jean (1993), “Saúde Pública, AIDS e Prostituição”, in: (ed.) Paulo NAUD, *Doenças Sexualmente Transmissíveis*, Porto Alegre, Brasil, Artes Médicas Sul Ltda., p. 287-288.

RWENGE, Mburano (1996), “Facteurs Contextuelles de la Transmission Sexuelle du SIDA en Afrique Subsaharienne: une Synthèse, in: *Colloque International sur les Sciences Sociales et le Sida en Afrique*, Dakar, (4-8 November), CORDESRIA/CNLS/ORSTOM.

SALIFSOW, Papa, Bineta GUEYE, Omar SYLLA and Awa Marie COLL-SECK (1996), “Pratiques Traditionnelles et Transmission du VIH au Sénégal: l’Exemple du Lévirat et du Sororat” in: *Colloque International sur les Sciences Sociales et le SIDA en Afrique*, Dakar, 4-8 November, CORDESRIA/CNLS/ORSTOM.

SERRANO, Ducelina et al (1998), HIV e SIDA em Angola, 1985-1998 Programa Nacional de Luta Contra o Sida, 44 p.

MAP Report-Annecey, Monitoring the AIDS Pandemic (1998), *Status and Trends of HIV/AIDS in the World*, Feb-June, p. 23-25.