The Global Fund
To Fight AIDS, Tuberculosis and Malaria

TB AND HIV CONCEPT NOTE

(ABOVE ALLOCATION REQUEST)

Investing for impact against tuberculosis and HIV

Countries with overlapping high burden of tuberculosis (TB) and HIV must submit a single concept note that presents each specific program in addition to any integrated and joint programming for the two diseases.

In requiring that the funding requests be presented together in a single concept note, the Global Fund aims at maximizing the impact of its investments to make an even greater contribution towards the vision of a world free of the burden of TB and HIV. Enhanced joint HIV and TB programming will allow to better target resources, to scale-up services and to increase their effectiveness and efficiency, quality and sustainability.

All concept notes should articulate an ambitious, strategically focused and technically sound investment, informed by the national health strategy and the national disease strategic plans (NSPs).

The concept note for TB and HIV is divided into the following sections:

Section 1: The description of the country's epidemiological and health systems context including barriers to access, the national response to date, country processes for reviewing and revising the response, and plans for further alignment of the NSPs, policies and interventions for both diseases.

Section 2: Information on the national funding landscape, additionality and sustainability

Section 3: The funding request to the Global Fund, including a programmatic gap analysis, rationale and description of the funding request, as presented in the modular template.

Section 4: Implementation arrangements and risk assessment.

IMPORTANT NOTE: **Applicants should refer to the TB and HIV Concept Note Instructions to complete this template.**

Country	**ANGOLA**		
Funding Request Start Date	**July 2016**	**Funding Request End Date**	**June 2018**
Principle Recipient(s)			
If the programs are to be managed as separate grants:			
Funding Request Start Date for HIV	**July 2016**	**Funding Request End Date for HIV**	**June 2018**
Principal Recipient(s) for HIV	**UNDP**		
Funding Request Start Date for TB	**July 2016**	**Funding Request End Date for TB**	**June 2018**
Principal Recipient(s) for TB	**Ministry of Health (MINSA)**		

FUNDING REQUEST SUMMARY TABLE

A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

Introduction

The Global Fund TRP has approved the within allocation grant amounts for TB and HIV, and has requested a supplementary submission to differentiate and define more clearly the above allocation request. The above allocation funding request will provide critical additional resources to support the National Tuberculosis Program (PNCT) and the National Institute to Fight Against HIV (INLS) to cover the financial gap not filled by the Government or other partners.

The Concept Note (CN) reflects a consensus reached during a national dialogue Forum held in July 2014 with wide participation of various sectors including Government, civil society, Key populations and partners. The above allocation adjustments to the CN have involved further stakeholder participation, particularly with civil society and partners for key populations to further focus the request.

This CN aims to strengthen collaboration of TB and HIV programs with joint programs to improve control of both TB and HIV diseases among co-infected patients. It will facilitate the expansion of health service network, strengthen the technical capacities of health workers and ensure progress towards universal access.

Current economic situation and mid-term outlook

During 2015, Angolan government has experienced an abrupt fall in revenue which is not expected to reverse in the next few years. This fall makes the implementation of many planned social policies impossible, and creates an immediate fiscal crisis that will take some time to adjust to.

Revenues: Angola´s economy and governmental activities depend on oil revenues in hard currency. Oil revenues represented an estimated 75% of governmental income in 2014 (IMF). Custom duties that represented 20% of governmental income in 2014 are a by-product of imports based again on oil income. Diamond sales have represented only 5% of government revenues in 2014[1]. There are no other exports above USD 5,000,000/ year.

Import dependence: Angola imports even the most basic consumption goods - 100% consumption of sugar, wheat and rice and 50% of maize production. The supply of all medical drugs is as well imported. Therefore, many competing priorities for hard currency expenditure exist.

Mid-term governmental income forecast: The oil price forecast until 2020 is low[2], due both to good mid-term supply as well as mid-term demand stabilization, incl. new technologies in energy production and storage, and GDP growth based on services rather than manufacturing). With FDI in Angola low due to number of barriers[3],the income generation in agriculture and new mining industries may develop only slowly.

Changes in policies: The Angolan government reacted correctly to the slump in revenues - devaluating kwanza from 100 to 160 to the USD, cutting out completely on the gasoline and diesel subsidies as per IMF recommendation, making import of food and medical drugs a priority and reinforcing support to the domestic agricultural production to replace imports.

TB program

The PNCT is currently implementing The Global Fund Round -9 grant, which will come to an end by August 2016. Funding available from Round 9 TB proposal is not included in this current request. It is worth mentioning that current concept note is intended to fill gaps in key activities not achieved by FG- R9. These activities will ensure sustainability in order to reach the goals of the PNCT.

HIV/AIDS program

HIV/AIDS program has been funded by Global Fund Round 4 that ended in June 2015. Financial resources currently available for implementation of HIV interventions depend on solely financing by Government that has been reduced by more than half because of the economic crisis within the country resulting from the continuing recession caused by the reduction in global oil prices.

This joint CN for above allocation request has been adapted to respond to the financial gaps generated by this economic situation that has had a significant impact on both programs as well as the TRP comments, increasing the focus on key and vulnerable populations and an improved gender focus.

TB and HIV Program Modules

[1] https://www.imf.org/external/country/AGO/rr/2015/020515.pdf
[2] http://www.reuters.com/article/us-iea-oil-idUSKCN0SZ02Y20151111
[3] http://www.doingbusiness.org/data/exploreeconomies/angola/

Closely linked to programmatic gaps that have been identified, HIV and TB programs plan to use resources to develop interventions underpinned by 10 modules for the HIV program and 4 modules by the TB programs linked by a joint TB-HIV collaboration module as follows:

a) HIV/AIDS Program Modules:

1. Prevention programs for General population
2. Prevention Programs for adolescents and youth
3. Prevention Programs for MSM & TGs
4. Prevention Programs for Sex workers
5. Prevention Programs for other vulnerable populations: Truck drivers
6. Prevention Programs for other vulnerable populations: Miners
7. Prevention of Maternal Transmission (PMTCT)
8. Treatment, care and support
9. Program Management
10. Health information systems and M&E

b) Control of HIV TB-HIV co-infection

c) Tuberculosis Program Modules

1. TB care and prevention
2. Control of TB-MR
3. Program Management
4. Health information systems and M&E

The requested contribution from the Global Fund has increased from US$ 64,245,048 to US$ 87,293,821 and is summarised in table 1..

The within allocation amounts have been adjusted in line with the GAC approved grant ceiling for grant making from US$ 35,491,321 to US$ 40,519,982.

The above allocation request has increased from US$ 28,753,727 to US$ 46,773,689 - comprised of US$ 37,089,506 for HIV, US$ 3,535,547 for HIV-TB collaboration and US$ 6,147,957 for TB.

Table 1. Summary of within and above allocation amounts by module

	Module	2016		2017		Total
		Within Allocation	Above Allocation	Within Allocation	Above Allocation	
HIV	Prevention: General population	1,138,410	3,078,310	1,050,000	2,109,570	7,376,290
	Prevention: Adolescents and youth	505,750	6,638,400	505,750	6,638,400	14,288,300
	Prevention: MSM & TGs	143,150	1,256,385		1,108,385	2,507,920
	Prevention: Sex workers	528,750	-	528750	-	1,057,500
	Prevention: Truck drivers	834,800	641,641	-	641,641	2,116,800
	Prevention: Miners	598,540	641,641		641,641	1,880,540
	Prevention: eMTCT	2,910,500	237,000	2,910,500	237,000	6,295,000

	Treatment , care and support	6,520,463	2,927,980	7,615,244	3,434,380	20,498,067
	Health information systems, M&E	-	2,184,885	-	1,675,110 -	3,859,995
	Program Management	700,721	99,033	689,953	79,112	1,568,819
HIV-TB	TB/HIV co-infection	345,263	1,634,826	- 439,918	1,900,721	4,320,728
TB	TB care and prevention	2,209,894	907,086	3,700,288	1,196,057	8,013,325
	Control of TB-MR	345,503	950,545	380,865	211,957	1,888,870
	Program Management	498,000	90,000	498,000	90,000	1,176,000
	Health information systems , M&E	449,431	1,065,851	549,955	1,015,371	3,080,608
PR	UNDP	1,683,533	1,410,853	1,683,553	1,410,853	6,188,812
	MoH	217,006	319,082	337,472	302,678	1,176,247
	Totals	**19,486,584**	**24,082,236**	**21,033,398**	**22,691,453**	**87,293,821**

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including descriptions of the TB and HIV disease epidemiology and their overlaps, the health systems and community systems setting, and the human rights situation.

1.1 Country Disease, Health Systems and Community Systems Context

With reference to the latest available epidemiological information for TB and HIV, and in addition to the portfolio analysis provided by the Global Fund, highlight:

a. The current and evolving epidemiology of the two diseases, including trends and any significant geographic variations in incidence or prevalence of TB and HIV. Include information on the prevalence of HIV among TB patients and TB incidence among people living with HIV/AIDS.

b. Key populations that may have disproportionately low access to prevention, treatment, care and support services, and the contributing factors to this inequity.

c. Key human rights barriers and gender inequalities that may impede access to health services.

d. The health systems and community systems context in the country, including any constraints relevant to effective implementation of the national TB and HIV programs including joint areas of both programs.

4-8 PAGES SUGGESTED

A. Evolving Epidemiology of TB and HIV in Angola

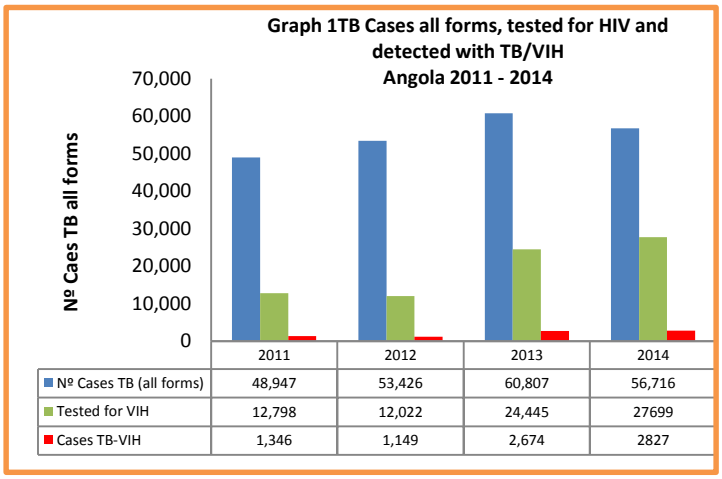
Introduction

The epidemiological analysis is founded on data from epidemiology reviews carried out for both HIV/AIDS and TB prior to the development of this concept note. The epidemiology review for HIV relied on findings from GARPAR report (2014), Sentinel surveillance study in pregnant women (Ministry of Health, 2014), routine programme data (INLS 2010-2014), HIV/AIDS NSP (PEN V-INLS 2015-2018); Integrated Bio-behavioural Surveillance Survey (IBBS; 2013) conducted in seven regions for female sex workers (FSWs), MSM and other KP and latest spectrum estimates were also used during the HIV epidemiological review process. The description of TB epidemiology relied on TB routine program data (PNCT), Epidemiological and Impact Analysis of TB (2010-2014), preliminary findings from the National TB Prevalence Survey (2015) and WHO TB report (2014).

The epidemiology of HIV/TB Co-infection

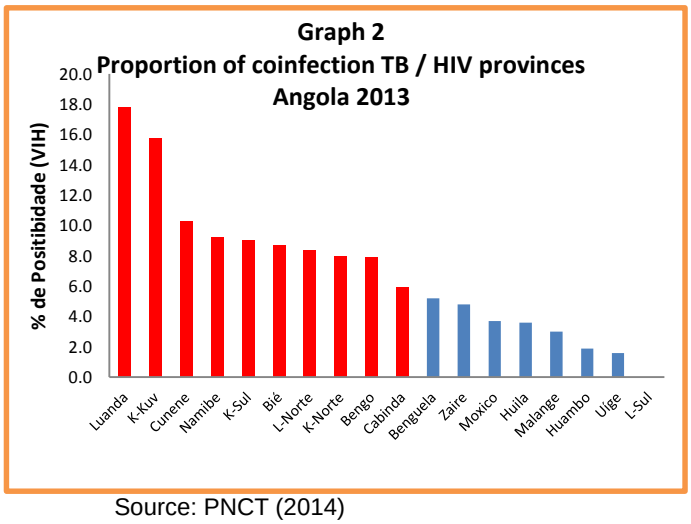
Angola is among the 22 high TB burden countries in the world and one of the countries highest TB burden in Africa. TB is the most common opportunistic infection affecting PLWHA, particularly in TB high burden countries. TB is also an important risk factor for PLWHA because of the rapid development of AIDS among HIV+ patients. This further exacerbates the mortality rate due to AIDS in Angola.

In 2013, 24,445 TB (all forms, graph 1, source PNCT) patients were tested for HIV, corresponding to 40.2% of patients registered with TB. Of these, 2,674 were HIV (+), equivalent to a positive rate of 12.8%. In 2014, 27,699 people with TB were tested, and 2,827 found to be co-infected, which represents 10.2%.



Source: PNTC (2015)

An analysis of HIV tests among TB patients (all forms, Graph 2, source PNCT) by province in 2013 found seven provinces had high level of detection of co-infection: Kuando-Kubango, Cabinda, Luanda, Cunene, Lunda-Norte, Uíge, Kwanza-Sul, Lunda-Sul e Namibe.



Source: PNCT (2014)

Due to the high risk of reactivation of latent tuberculosis infection among HIV-positive patients, a major challenge for the country is the expansion of access to prophylaxis such as Isoniazid for the eligible patients (according to policy), as well as ensuring preventive therapy with Cotrimoxazole for co-infected TB/HIV patients. Currently, there is low coverage of TB/HIV services (screening, IPT, Cotrimoxazole and ART) and data collection is inadequate. The HIV program has not yet implemented TB screening and IPT among PLHIV attending HCT, PMTCT and ART sites. Under this request, the NTP and INLS plan to strengthen the collaboration of TB/HIV programs and improve the management of TB/HIV co-infection by reviving the TB/HIV technical working group and reviewing its terms of reference; reviewing the TB/HIV collaboration guidelines; implement joint TB/HIV planning, joint training and supervision; monitoring and evaluation/information systems; and joint service delivery in management of TB/HIV co-infection at HCT, PMTCT, ART and TB-DOTS sites.

TB and HIV rates in Children

Based on PMTCT programme data and spectrum projections it is estimated that 4,600 were reached with paediatric HIV care out of 35385 children infected with HIV from their

mothers in 2013 representing 13% coverage. As is the case in many countries, the exact magnitude of TB in children is not known in Angola because of limitations of data availability and diagnostic challenges (EID) in this vulnerable population. In 2014, available information from National Tuberculosis and Leprosy Program (NTLP) indicates that children below 15 years account for less that 10% of all the TB cases notified. The diagnosis and management of TB in children with HIV has posed a significant challenge due to a number of factors, such as nonspecific clinical presentation and limited access to culture and molecular diagnostic facilities. Angola has intensified efforts for active TB case finding amongst HIV infected children.

TB and HIV rates by age-group and sex

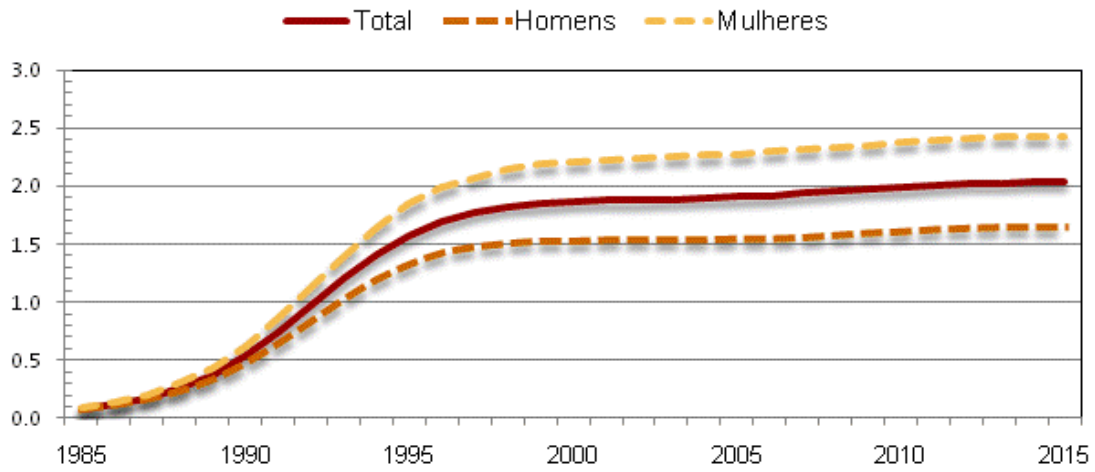
Whereas TB heavily affects many subpopulations and geographical areas in Angola, males bear the brunt of the burden as they account for about two thirds of the notified TB cases (57% are males, while 43% are females). However, HIV prevalence among males is lower than that of females (1.7% vs 3%;), HIV is not the only risk for TB infection; other factors such as occupation and overcrowding may increase the risk of TB infection among males. The age-sex distribution of the new smear positive cases as in previous years shows that, the highest number of TB cases notified was in the age groups of 15-44 years for both males and females. These age groups are also deeply burdened with HIV in the country.

Epidemiology of HIV/AIDS in Angola

The HIV prevalence for Angola is estimated at 2.35% among adults aged 15 to 49 years. The prevalence has steadily remained at this level over the past decade since it hiked to these levels between 1995- 2000. According to spectrum projections, in 2013 an estimated 252,453 adults (15 to 49) were living with HIV / AIDS in Angola and 29,103 children (0-14 years). The same estimates indicate 145.385 HIV-positive women, 15.575 HIV-positive pregnant and 37,153 orphans (0-17 years) from AIDS. Based on data collected in sentinel sites, sexual transmission is the main mode of transmission of HIV (79.2%), with heterosexual transmission being the most frequent.

Graph 3, shows the trend of estimated prevalence from 1985 to 2015; It is observed that the prevalence continued to rise steadily along the years and then stabilized around 2000. In the context of the Angola, these trends can be interpreted as a consequence of increased access to treatment that reduces mortality by AIDS and increases the number of people living with HIV or AIDS.

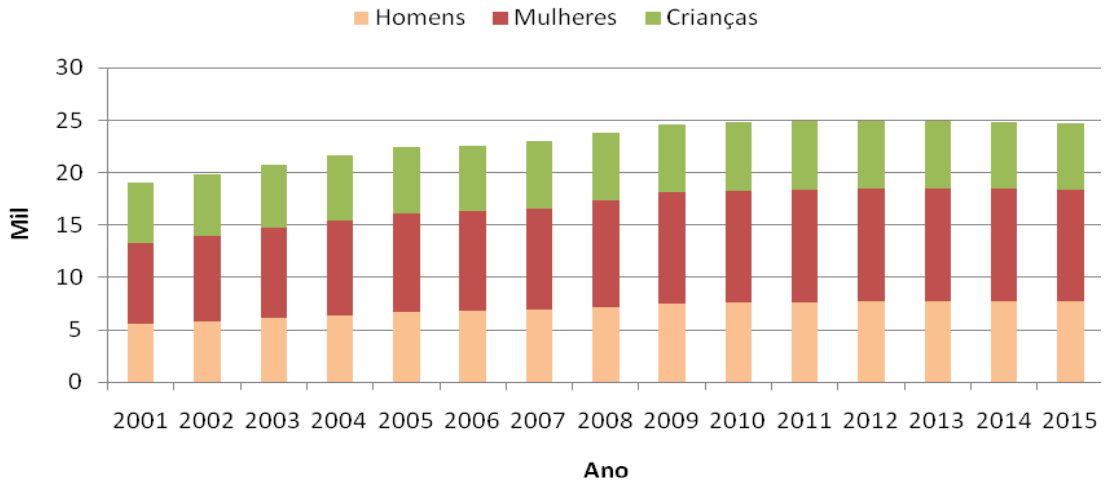
Graph 3.Trends in HIV Prevalence in Adults (15-49) – 1985-2015



Source: Estimates EPP / Spectrum 2013

However, there is persistent increase of HIV prevalence among children that requires specific attention. Additionally, HIV prevalence is higher in women than in men and there is persistent significant difference over time in the number of cases between women and men.

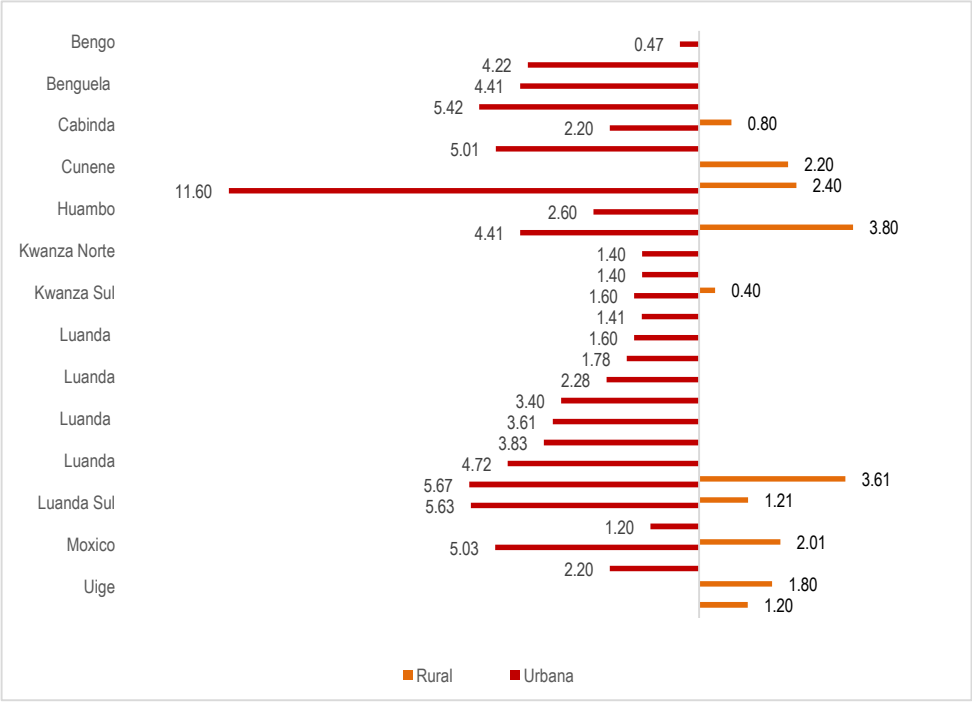
Graph 4. Trends in HIV incidence in Men, Women and children. Angola 2001-2015



Source: EPP / SPECTRUM, 2013

Among pregnant women, ANC sero-prevalence survey showed an overall prevalence of 3% and a rate of 2% among 15-24 years old women). The same prevalence study realized in eighteen (18) provinces showed significant differences in geographical repartition in prevalence of HIV and AIDS within the country (Graph 5).

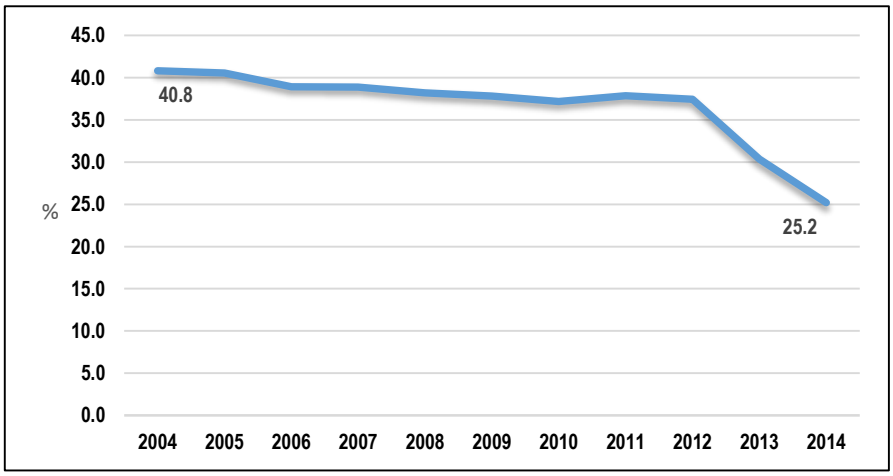
Graph 5. Average HIV prevalence in pregnant women, in urban and rural provinces. Angola, 2014.



Source: Sero-prevalence study in pregnant women: Ministry of Health, 2014.

Regarding vertical transmission rate, Graph 6 shows the trend of estimates by SPECTRUM[4], indicating a progressive decrease from 40.8% in 2004 to 37.5% in 2012 and 25.2% in 2014. This decrease can be explained by the ongoing interventions of PMTCT.

Graph 6. Trend of Vertical Transmission Rate of HIV. Angola 2004- 2014

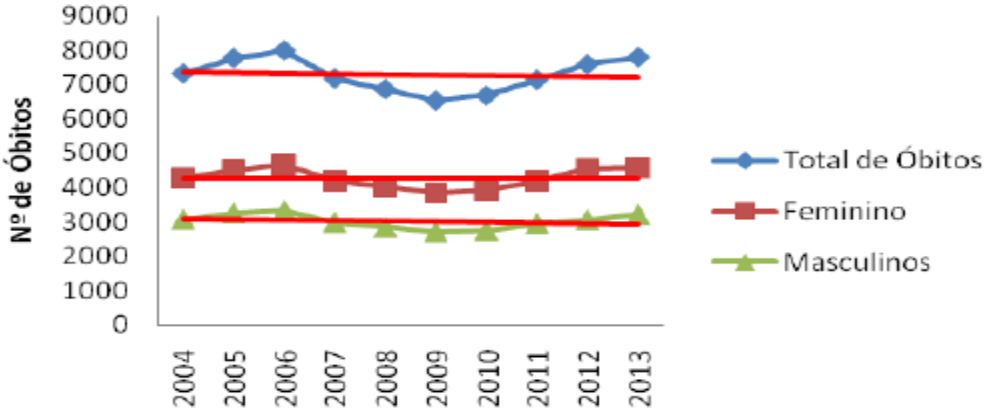


Source: Spectrum/EPP 2015

Mortality

There are major challenge in obtaining data of mortality of PLHIV due to the lack of a national death registration system. However, estimates from Spectrum 2013 show 11,515 persons AIDS deaths (adults and children). It is noteworthy that during the last ten years there has a stabilization in mortality trends, with an annual average of 4.269 deaths in woman and 3,014 deaths in men. The graph 7 shows the evolution of the estimated number deaths related to AIDS in the period 2004 – 2013 (EPP/SPECTRUM).

Graph 7. Evolution of the number deaths related to AIDS - Angola, 2004 - 2013.



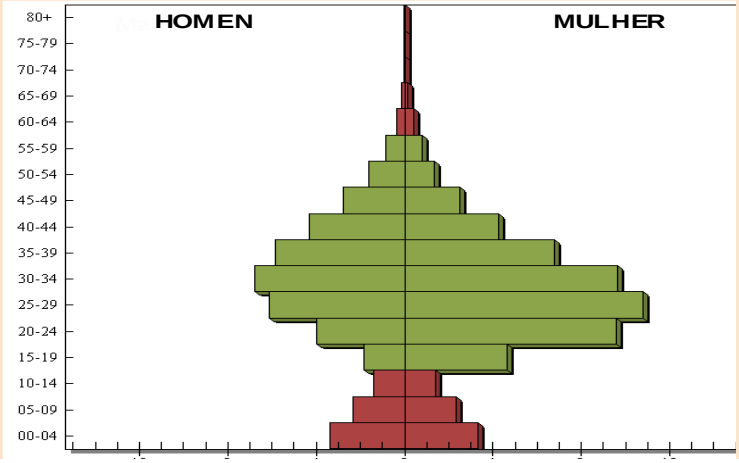
Source: PEN V - INLS

[4] *Anexo 10 a – 10b Spectrum, tabelas março 2015*

Risk Factor Analysis

Determinants that contribute to heightened risk of and vulnerability to HIV infection in the Angola include epidemiological variables, such as age, gender, social-economic status and geographical location (see ANC study). Other key determinants include socio-cultural practices (multiple sexual partners); low condom use and jobs that portend enhanced possibilities of engaging in high risk sexual behaviours: truck drivers, miners, migrants, other rapidly expanding extractive industries, and fishing. Risky sexual behaviours amongst young people aged 15 -24 years remains a challenge – The data show high infection rates among young girls and women 15-24 years. Figure 1 illustrated the gender and age vulnerability showing that young girls and women are especially vulnerable to HIV infection.

Figure 2. Pyramide of reported seropositive cases by age and gender, 2013



Source: DVEI – INLS

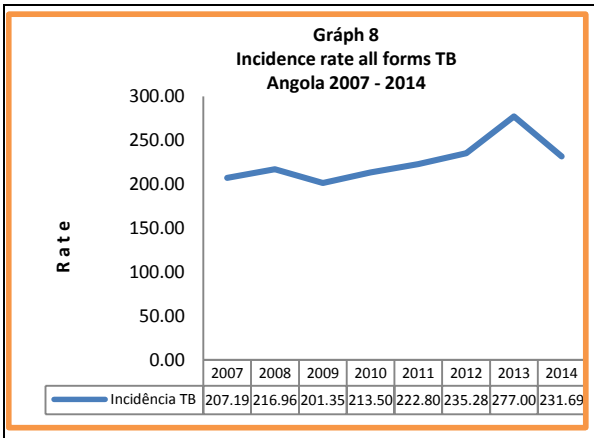
Epidemiology of Tuberculosis in Angola

Prevalence and Incidence of TB in Angola

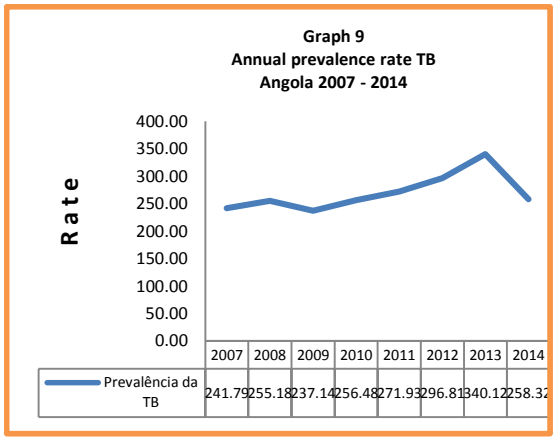
The most recent WHO-modelled estimates in 2013, show that the prevalence of all forms of TB stands at 423 per 100,000 with incidence of 320 per 100,000 and case detection rates determined at 85%.

According to program data (PNCT), the rate of incidence of TB in 2013 was no more than 277 per 100,000 inhabitants[5] and for 2014, 231 x 100.000 inhabitants (graph 8); and the prevalence rate of TB in 2013 was estimated at no more than 340 per 100,000 inhabitants; for 2014 the prevalence of all TB cases was 258 per 100,000 inhabitants (graph 9)

[5] *ANEXO 13 PEN- TB 2013 - 2017*



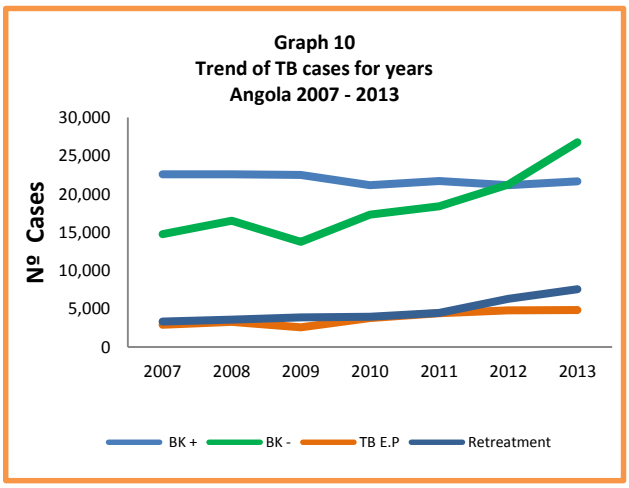
Source PNCT



Source PNCT

TB Case Notification in Angola

A retrospective analysis of the trend of all forms of tuberculosis cases notified from 2007 to 2014 (graph 10), shows that a peak in the notification has been reached in 2013, a decline has been observed in 2014 in TB notification. Moreover, the trend of BK- (smear negative) cases remains high compared to BK+ (smear positive) due to the fact that the main means of diagnosis were clinical and radiological versus the sputum smear. The retreatment as well as the extra pulmonary TB tend to be high, which is a compelling situation that can hide MDR-TB cases.

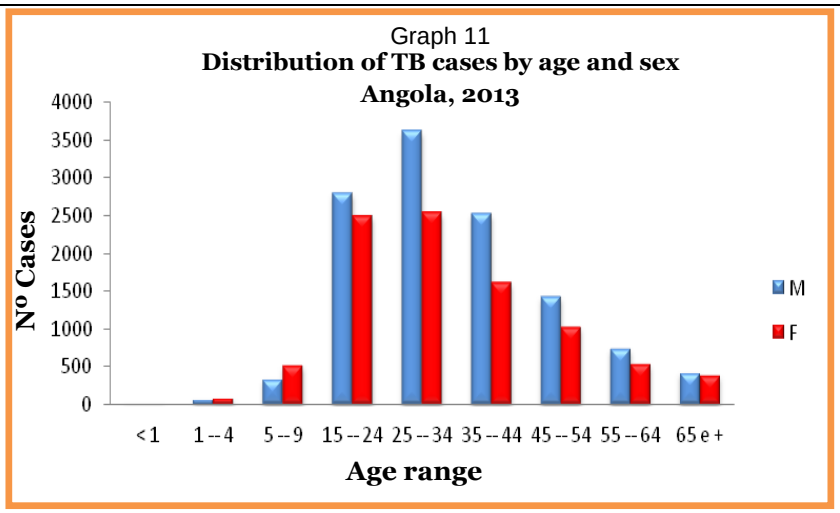


Source PNCT(2014)

The decline would be attributed to low engagement of community based groups, lack of new diagnostic technologies and others in case-finding activities. Key contributing factors to low TB case detection include poor access to diagnostic services, very low involvement of private sector and non-state actors, inadequate supportive supervision, inadequate public knowledge of TB and stigma, and inadequate penetration of community-based interventions into vulnerable communities. These are areas where more resources must be invested for maximum impact.

Age-sex characteristics of TB in Angola

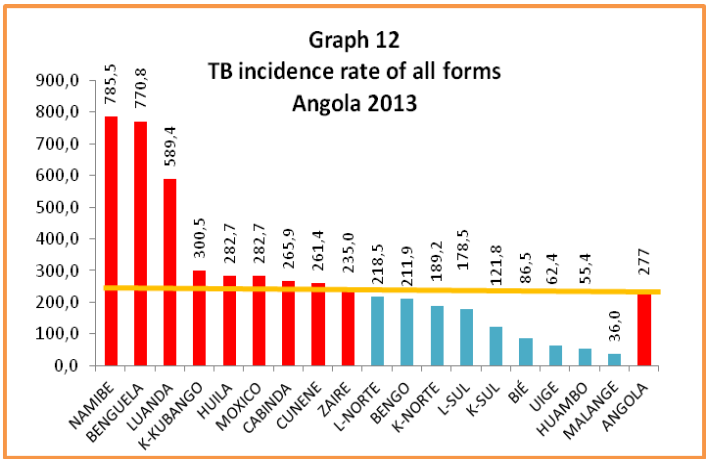
Case distribution of all form of registered TB cases according to sex in 2013 shows that 57% (34,659 cases) were male and 43% (26,148 cases) were female with a sex ratio (male/female) of 1.3. The most affected age group was 25 to 34 years (20.3%) while the age group 35 to 44 years represents 2.7%, both age groups belong to more productive ages economically (Graph 11).



Source PNCT

Geographical characteristics of TB epidemic in Angola

The rate of TB incidence in all forms distributed among provinces shows that the problem of TB is countrywide. In nine provinces (graph 12, source PNCT), the rate of incidence is greater than the national average incidence rate of 277 per 100,000, namely the provinces of Namibe, followed by Benguela, Luanda, Kuando-Kubango, Huila, Moxico, Cabinda, Cunene, and Zaire. This justifies the need to for the PNCT to roll out priority activities to the overall network of health facilities without putting aside any of the 18 provinces.



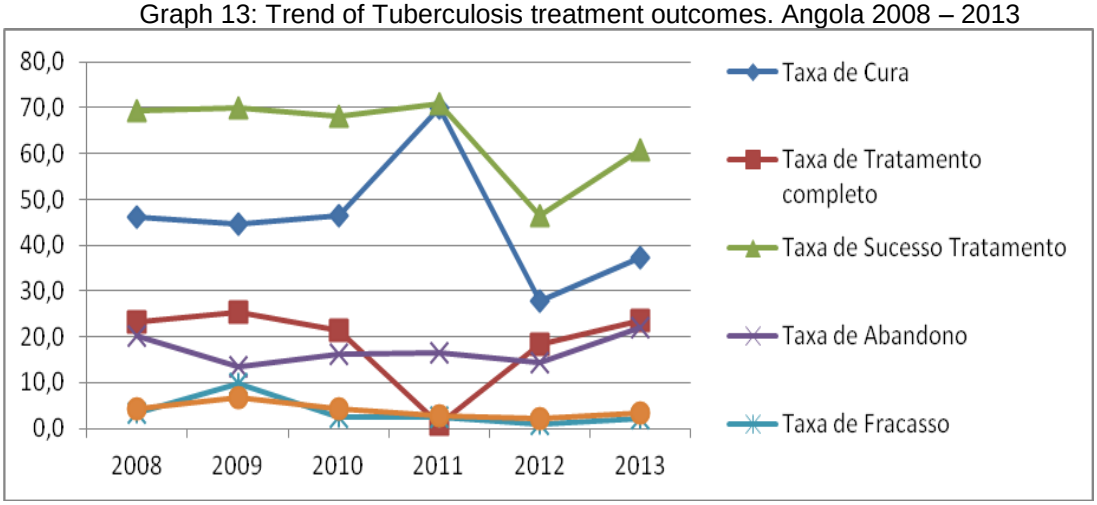
Treatment success

The trends of TB treatment outcome (2008 to 2013, Graph 13), shows that the treatment success rate decreased from 71% in 2011 to 46% in 2012; the cure rate decrease from 70% in 2012 to 27.9% in 2013; Dropout rate was high throughout the period of analysis; the death rate remain stable with an average of 4.3% and finally the rate of failure to treatment that appeared quite high was in 2009 (9.8%) and further reduction by 2013.

The reduction in cure rates and treatment success observed in 2012 was due to the fact that the programme has strengthened the monitoring and evaluation team, whose responsibility was to review the instruments and calculation of indicators; and it was found that in the calculation of these indicators in previous years the number of patients followed in treatment was used as the denominator. From 2012 the program started to use number

of reported cases from the corresponding cohort as the denominator as correct and universally used.

Graph 13: Trend of Tuberculosis treatment outcomes. Angola 2008 – 2013



Source PNCT (2014)

TB mortality trends in Angola

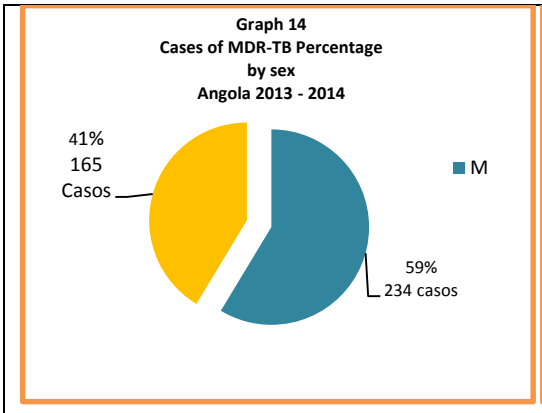
TB-related mortality is difficult to estimate at present because of TB death related data are yet to be incorporated into national vital registration system. The WHO estimated TB mortality rate (excluding HIV-related TB) for Angola stood at 32 per 100,000 in 2013. While HIV prevalence is stabilizing, so is its impact on TB.

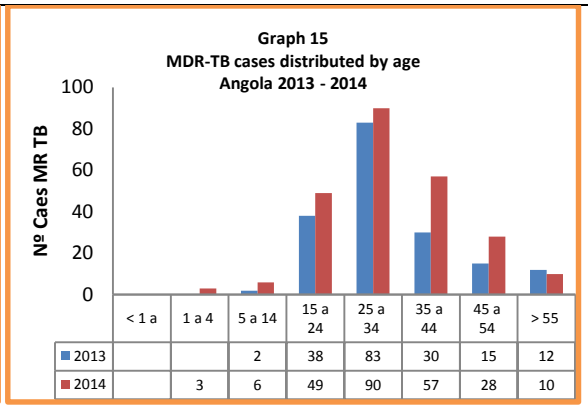
Prevalence of multidrug-resistant TB in Angola

In Angola, MDR-TB prevalence is not known, as no study related to MDR-TB has been conducted. A study of MDR-TB[6] was planned, but execution has been delayed because of lack of resources and facilities for diagnosis[7]. WHO estimated that there were 920 cases of MDR in Angola in 2014 among new TB cases and 1,500 cases MDR-TB among retreatment cases. However, only 17% were detected of all estimated cases, of which more than 80% had a history of defaulters and failure to treatment. The cases of TB-MR were notified mainly in the provinces of Luanda, Benguela and Huambo, with a reduced number in Kwanza-Norte, Huila, Kwanza-Sul, Malange, Cunene and Bengo.

During 2013 and 2014, using Bactec-960 (liquid culture) and GeneXpert technology, a u3total of 423 cases of TB-MR were detected, 180 were diagnosed in 2013 and 243 in 2014. Out of these patients, 60% were resistant to streptomycin and 40% to Isoniazid.

[6] ANEXO Nº 15 Relatório PNCT 2014
[7] Anexo Nº 2ª Protocolo estudo MR-TB Angola and Anexo 2b Draft Manual TB-MR-Angola





	< 1 a	1 a 4	5 a 14	15 a 24	25 a 34	35 a 44	45 a 54	> 55
2013			2	38	83	30	15	12
2014		3	6	49	90	57	28	10

The gender distribution shows that 59% of TB cases were male and 41% female (graph 14). There were a greater number of MDR TB cases reported among 25 to 34 year olds, followed by age groups 35-44 and 15-24, these groups are considered to be the economically active age groups.

In Angola, there is a network of 11 Hospitals Sanatoriums and 10 diagnostic and treatment centres (DATS) with capacity in the management of complicated TB and MDR-TB. There are three (3) laboratories performing diagnosis of MDR-TB (Luanda, Benguela and Huambo). This network of facilities will be improved with the acquisition of 10 GeneXpert machines by the Government and 4 others through GF Round 9. Because the GF Round 9 disbursement window has closed, these 4 machines are now included within allocation and a further 4 added for the above allocation request. Laboratory TB guidelines will be updated taking into account annual action plans

B. Key populations (KPs) that may have disproportionately low access to HIV and TB services

HIV among key affected populations in Angola

Whereas Angola has a generalized HIV epidemic, there are pockets of concentrated epidemics especially among KPs. In Angola, KPs include sex workers and their clients, MSM and TGs. Other vulnerable groups that need special attention are miners, truck drivers, prisoners, young girls and young women, PLHIV, sero-discordant couples, fishing communities and migrant workers.

KPs are at higher risk of HIV infection or transmission, and likely to face societal barriers to accessing general HIV prevention and care interventions. KPs play a key role in the way HIV spreads, and their involvement is vital for an effective and sustainable response to HIV. KPs are also at a higher risk of other infections such as syphilis, Hepatitis B and Hepatitis C.

HIV prevalence among KPs is much higher than that of the general population. A 2011 behavioral & serological survey conducted among men who have sex with men in Luanda estimated the MSM population size for Luanda at 6,236 with an adjusted HIV prevalence at 3.8%. 50% of participants identified themselves as bisexual, 25% as MSM, and 18% homosexual/gay. Additionally 37% reported having participated in commercial sex with men, women, or transvestites (often concurrently). Another study conducted in Luanda in 2011, with a sample of 351 men, having sex with men, indicated that the HIV prevalence in this group is around 8.2%. Based on the information above, it is easy to see how HIV could be transmitted from MSMs to the general population. The study also reported that only 38 % of this high-risk group had ever tested for HIV. Nearly half the participants (46

%) reported experiencing homophobia (physically attacked, offended or discriminated against) and 25% reported being physically forced to have sex against their will.

Among sex workers, in 2006 a behavioral study has been conducted in two cities with a sample of 1,001 sex workers in Luanda and 327 sex workers in Cabinda. Results showed an HIV prevalence of 23%. This study also highlighted that this population had very little knowledge and a low perception of infection risks (23.3%), 97% have heard at least once about HIV/AIDS and 67% used preservatives. A biological and behavioral surveillance survey (BBSS) conducted in 2009 examined transactional sex among 500 women (aged 15-25 years old) living in a town bordering Namibia in Angola. It found that 8.5 % of the participants were positive for HIV while 3.4 % tested positive for syphilis. Nearly half (46 %) reported never having an HIV test, half reported having at least one partner in the last year who was more than 10 years older, and 76.5 % reported having concurrent relationships in their last partnership. A third of the young women reported being forced to have sex against their will at some point in their lives, and 16 % reported being beaten by a sexual partner in the last year. Another study was conducted in Cunene Province (2011), with a sample of 500 Sex workers (SW), demonstrated that HIV prevalence was around 7.2% in this vulnerable group. .

TB among key affected populations in Angola

A number of different sub-populations have been identified as TB-key affected populations in Angola, based on a combination of modelling, globally recognized risk factors for TB, TB prevalence survey (PNCT) data, epidemiological assessment data and programme data. The TB-key affected populations include prisoners, young people, elderly, children, miners and mining communities, diabetics, drug addicts and construction workers. All these groups are exposed to numerous risk factors: low education, poor access to health services, overcrowded housing, poor ventilation, malnutrition and drug abuse, and they often carry diseases that can affect the immune system. A priority and challenge for PNCT is the early detection and rapid treatment of smear-positive cases as a means of breaking the TB transmission chain among these TB vulnerable groups.

Among prisoners[8], a partnership will be established between PNCT and MINIT to strengthen prevention and control of TB. TB services will be created in accordance with PNCT policy, with the active searching for contacts within prisons with emphasis on the systematic examination of sputum of every new entry. Within the current TB-FG/R9 grant, a study of the prevalence of TB, HIV HIV-TB and MDR-TB was provided for, there is at the moment no other study at prisons level Currently, there is one ongoing study on TB and diabetes; no other studies in the context of TB have be performed.

Another area of interest in Angola are studies about the association between TB and diabetes[9]. Owing to low levels of food production that make fast food and less healthy food more affordable for workers and for those living in crowded urban areas, an increase in the rate of diabetes has been observed in Angola. Since August 2014, a two-year project is being implemented by CUAMM, co-financed by the World Diabetes Foundation and Doctors with Africa-CUAMM. The aim of the project is to measure the prevalence of diabetes among suspected cases and among TB patients accessing four UDT centers selected within the province of Luanda. These are the Luanda Anti-tuberculosis Dispensary, Divine Providence Hospital, and the Health Centers of Cariango and Cacuaco. In 2014 a study was conducted in Luanda on linkages between TB and diabetes, 1009 diabetes patients' suspects from having TB have been followed. Partial data showed a co-morbidity (Diabetes-TB) of around 41% and co-morbidity with high blood pressure of 29%.

[8] *ANEXO Nº 3 Plano colaborativo TB nas prisões*
[9] *ANEXO Nº 18 Estudo TB-Diabetes em Angola, CUAMM 2015*

The NTP and IOM (International Organization for migration of Angola) have planned to carry out an assessment of the situation of TB in migrants and Miners in order to facilitate their integration into Regional TB Project. However, provincial programs and partnerships ensure TB control activities in these groups. Cross-borders meetings for TB control have been held in the provinces of Kuando Kubango, Cunene, Namibe; a Memorandum of understanding on Public Health issues in border areas has been signed between Angola, Namibia, the DRC, Congo and Zambia since the year 2011 (attached who report).

Regarding children as a vulnerable group, the national standards and NSP-TB defined specific interventions for TB control in children. On the other hand, TWG for TB includes representatives from pediatric society, vaccination program and specialized hospitals. In compliance with regional guidelines a joint plan for TB/HIV for maternal and child health was developed and provides a framework for: (i) preparation of TB Manual for children; (ii) training of health personnel at various levels, (iii) implementation of an integrated package of care to children and pregnant women in health services network, with technical assistance from WHO. The NTP plans to review the information system in order to have the information about children disaggregated by age, sex, and clinical diagnosis in order to have a better epidemiological profile of TB in children.

Other vulnerable groups include the homeless, who are mostly teenagers, drug users, malnourished and socially excluded. Particular attention will be paid to these population groups and rigorous surveillance will be applied, because these groups do not has a fixed location with a high risk to drop out treatment and therefore they may contribute to increased rates of MDR-TB.

C. KPs, Human Rights Barriers and Gender Inequalities

The extent of human rights barriers in TB and HIV services provision is not well documented. Generally there is low understanding on the part of patients, health care providers and general public with regard to legal and patient rights in the provision of health services; the existing laws and regulations do not directly address specific needs of KPs with respect to health services provision and human rights. There is an AIDS law (Presidential Decree nº 08/04/2004) that aims to protect PLHIV from discriminatory practices. Although Angola passed the 2004 HIV and AIDS Prevention and Control Act that is intended to promote patients' rights and stigma free services, the act does not explicitly address the needs of KPs.

Stigma and discrimination against sexual minorities (LGBT/MSM), however subtle, contribute as a barrier to access health services. Articles 70 and 71 of the penal code, inherited from the colonial regime and as yet not revised, prohibit homosexual acts, considering them an offense to public moral. As a result, this high-risk population is largely hidden and has not been reached with any degree of success by HIV prevention services. Moreover, a number of studies have shown that the perception of risk in relation to men's health is very low, leading to the adoption of risky behavior (such as not using condoms) and neglect of personal health. Together, these factors place MSM in the vulnerable population category and, as the data show, as a high incidence with need of strategic interventions. In addition to discrimination, sex work is not legalized in Angola. Thus, many sex workers who are victims of violence do not report these incidents to the authorities.

The Constitutional Law[10] adopted in 2010, Article 35, reaffirms gender equality in the family, in society and in the state. Men and women have equal rights and should have access to equal opportunities. However, there are customs and practices that discriminate against

[10] *ANEXO Nº 20, Lei Constitucional de Angola*

women in social, cultural, economic and political contexts, and that reinforce gender inequality. The choice whether or not to have children, agreeing on whether to use the condoms or not, or the decision to go to the health clinic is not left to the woman. It is the man who decides when the woman can seek health care, use condoms or any form of contraception within and outside marriage. Social practices reinforcing gender inequality include the acceptance that a man can have multiple partners in a stable relationship, and premature marriage. All this makes women more vulnerable and at greater risk to HIV infection.

D. Health Systems and Community Systems Analysis/Context in the Country

Health Systems Analysis and Context

The National Health System in Angola includes three sectors: the Public, the Private and the Traditional sector. The National Health Service (NHS) is composed by all health facilities under the supervision of the Ministry of Health (MINSA), meaning under the coordination and methodological guidance of MINSA and under the management of Provincial Governments and Municipal Administrations, totalling to 2,366 health units in the three health care levels.[11] The for-profit private sector is comprised of private clinics that provide services to a large proportion of the population especially in large urban centres. The not for-profit health sector delivers services from health facilities managed by NGOs and Faith Based Organizations, assisting especially the poorest populations. The Traditional sector (traditional medicine) is mostly restricted to rural areas and provides services to a considerable portion of the population, especially where there is poor formal health service coverage. An important percentage of health expenditure is in the private for-profit sector.

Domestic funds financed 98% of public health care. The Government paid (67%) of total public health expenditure; The remainder was paid directly by households (24%) and by other funds (9%)(Source: WHO Health System Financing Country Profile, 2013). Total health expenditure, as a proportion of the state budget, has remained relatively stable in the same period, with an average of 4.58%.

In 2012 the government produced the National Health Development Plan (PNDS), an ambitious plan for investment in health system and services through to 2025. A participatory national dialogue identified gaps that defined the 9 PNDS programmes. Main programs (intervention areas) from the PNDS include:

1. Prevention and Fight Against Diseases Program
2. Primary Care and Hospital Support Program
3. Management and Human Resource Development Program
4. Research in Health Development Program
5. Management and Health Network Expansion Program
6. Management, Procurement and Logistics, Pharmaceutical Sector Development and Medical Equipment Program
7. Information System Development and Health Management Program:
8. Health Sector Institutional Frame work Development Program
9. Funding program and financial sustainability of the National Health System

The main strategic plans, the National Health Development Plan (PNDS) and Diseases Plans (National AIDS Strategic Plan 2015-2018, draft Malaria Strategic Plan 2016-2020

[11] The primary healthcare level includes the health posts and centres as well as the municipal hospitals; the secondary level is represented by the general or provincial hospitals and the specialized ones, where the primary level facilities refer patients to; the third level is made by nacional or central hospitals that are reference from the secundary facilities – National Health Policy, Presidencial Law n° 262/10 of the 24th November, DR I Série, nº 222.

and PEN=TB 2013-2017), establish that the current problems faced by the National Health System are related to:

- Limited access to health services particularly in rural areas;
- Type and quality of services delivered by the health facilities are still insufficient to cover the needs of the population;
- Weak referral and counter-referral system between the three levels of the NHS;
- Insufficient skilled human resources and unbalanced distribution of personnel between rural and urban areas; significant turnover of health personnel; demotivated staff;
- Limited logistic and communication means;
- Lack of financial resources; and
- Lack of service integration leading to inadequate management of TB /HIV co-infection.

The drop oil in price in 2014 from an average of around US$100 per barrel, peaking in June 2014 at US$115, falling by October 2014 to $81, to $40 per barrel in early 2015 and to US$ 31 in January 2016 has had a direct impact on all government programmes. Health expenditure planned for year 2015 was reduced by 33% due to this recent drop in oil prices. However, at AKz 405,482 million, the original 2015 budget was a 28.4% increase on 2014 and 5.59% of GDP, showing the commitment to improving health expenditure.

Community Systems Analysis and Context

The Angola health care has for decades been based on hospital care and therefore, there has never been a structured community-based health care system. The country never had a substantive policy regarding the organization of the community based services. However, there were several attempts from partners to establish a community health workforce, known as Community Health Agents (ACS) in different Provinces. Community activities have not been sustainable, lasting only until the end of their respective projects. With no guidance from the Ministry of Health, NGOs and partners had different approaches to CSS in general, as well as the scope of activities and processes for the management of ACS.

The existence of networks of NGO and CBO serve to protect the democratic process, respect of human rights, transparency and social accountability. Community activities and services have been proven to be essential for achieving improved health outcomes for the three diseases. Community peer members that are also people living with HIV (PLHIV) and key population are in a better position to understand and address the needs of affected populations bringing more credibility, trust in the service and relevance to the messages transmitted; encouraging communities to use health services delivered by the NHS.

PLHIV peers have played a big role to increase voluntary participation in HIV counselling and testing and adherence to chronic treatments such as for HIV and TB. Early identification and referral to health facilities of suspected Malaria cases is also an essential activity carried out by community volunteers trained in order to recognize signs and symptoms of diseases. Communities trust the peers and the work they do to improve access to primary health care on a voluntary basis. However, the attrition amongst trained community activists is high and it is increasingly important to ensure stability to this resource through the introduction of uniform stipends.

Since 2002, some provinces like Luanda, Huambo and Huila, have tried to keep their ACS through their provincial governments with support from UNICEF and other partners and with private sector investments. The Luanda DPS reported a positive experience with ACS in the fight against cholera in 2006. In 2008, the Provincial Government paid 1,843 ACS working in Luanda province. Each ACS was posted in a Health Unit with a supervisor and covered 100 families in geographically defined urban areas and 300 families in rural areas, focusing on maternal and child health activities, Malaria, Diabetes and Hypertension. In Huambo, the provincial government contracted a Brazilian NGO, AMOSMID to train ACS and supervise the health services they were delivering. In 2010 the first Community DOTS project in the country was implemented in the provinces of Huambo and Bié with support from USAID. The INLS expanded the training of community peers called Patients Trainers

Helpers (PAF) integrated into primary health facilities. Experience has shown that the involvement of people living with HIV (PLHIV) was very helpful in the support of service providers linking health facilities to communities.

MINSA and the Ministry of Territorial Administration (MAT) have worked to develop a policy for the deployment of Community and Health Development Agents (*Agentes de Desenvolvimento Communitario e de Sanitaria)* also called "ADECOs" at community level for several community based interventions including health prevention and promotion activities (Annex 32-RCN ADECOs Policy). MAT has declared an absolute commitment to pay ADECOS as a formal part of the health system from 2018. In 2014, the ADECOS national policy framework was approved and instituted to replace the several isolated community initiatives.

The July 2015 draft policy (pg. 20) sets an initial target of 1,080 ADECOS to be trained in 6 Provinces (18 municipalities) and it is planned that by 2017 a total of 14,100 ADECOS are to be deployed to cover the entire country. Each ADECO will cover a population of 500-1500 (100-300 families) depending on the complexity of their responsibilities, is expected to work 40 hours per week and will receive US$150 per month. Salaries and operational costs will be covered by MAT. Ultimately the 3-month ADECOS curriculum includes training on EPI+, neonatal care, safe delivery, key family competencies/practices and the capacity to provide some basic services (especially treatment of water, ORS use). The municipal health centres, through their integrated health teams will be responsible for performing routine supervision and monitoring the quality of service delivery provided by ADECOS.

The role of ADECOS will be social mobilization, promotion of healthy behaviours, prevention of diseases, monitoring of treatment for some communicable diseases, referral from communities to health facilities and vice versa. However, there is recognition that the disease programmes have used ACS successfully for HIV counselling and testing, and TB DOTS. Angola has submitted an HSS concept note to support ADECOS and INLS/PNCT will leverage their roles during TB/HIV program implementation.

1.2 National Disease Strategic Plans

With clear references to the **current** TB and HIV national disease strategic plan(s) and supporting documentation (including the name of the annexed documents and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas under each of the TB and HIV programs including those that address joint areas.

b. Implementation to date, including the main outcomes and impact achieved under the HIV and TB programs. In your response, also include the current implementation of TB/HIV collaborative activities under the national programs.

c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints and barriers described in question 1.1 are currently being addressed.

d. The main areas of linkage with the national health strategy, including how implementation of this strategy impacts the relevant disease outcomes.

e. Country processes for reviewing and revising the national disease strategic plan(s). Explain the process and timeline for the development of a new plan and describe how key populations will be meaningfully engaged.

4-5 PAGES SUGGESTED

A. Analysis of the National strategic plans for TB and HIV in Angola

HIV/AIDS National Strategic Plan (*V PEN SIDA 2015-2018)*

V PEN-AIDS[12], takes the principles and broad strategic lines envisaged in a number of government documents on the HIV/AIDS theme, especially the National Health Development Plan 2012-2025, the Strategic Plan for Poverty Reduction; the document Accelerated Response to HIV and AIDS; and the Plan for the Elimination of Mother to Child HIV Transmission[13].

The Fight Against AIDS in Angola involves national and international organizations, whose strategic lines, contained in the PEN-AIDS, guide the fight against AIDS, reaffirming the integrated vision and the alliance of the Health Sector with the Public-Private Sector and civil society, through the INLS, the regulatory body, executor and evaluator of the national response policies in the fight against STI/HIV-AIDS and hepatitis in Angola.[14].

Goals , Objectives, Priority program areas

The overall goal of V PEN-SIDA 2015-2018 is to “strengthen the capacity of the national response in the control of STI/HIV/AIDS, and viral hepatitis, maintaining a rate of below 3% HIV sero-prevalence among the general population.”

The Objectives of V PEN-SIDA (2015 – 2018) are:

1. Reduce from 15.8% to 10% sexual relations with more than one partner in the population 15-49 years.
2. Increase the use of condoms from 19% to 25% among women; and from 43% to 55% among men. Increase from 74% to 90% amongst FSW and women who report condom use with their last client.

[12] *ANEXO Nº 9 PEN SIDA 2015 - 2018*
[13] *ANEXO Nº 21 : Plano de eliminação da Transmissão do VIH mãe para filho – INLS*
[14] V PEN SIDA 2015-2018

3. Maintain the prevalence of HIV among pregnant women under 3%.
4. Reduce the rate of vertical transmission below 5%
5. Increase PMTCT coverage from 39% to 90% of HIV positive pregnant women.
6. Increase from 52% to 90% the follow-up of HIV positive pregnant women on ART.
7. Increase the proportion of TB cases (all cases) tested for HIV from 25% to 95% and the treatment of TB in 100% of PLHIV suspected of co-infection.
8. Improve the system of monitoring and evaluation, aligning information records in 100% of services, hospitals, and public/private partnerships involved.

The PEN AIDS 2015-2018 has six priority strategies (strategic axes) to achieve the goals and objectives, and to guide overall national response for prevention and control of HIV infection in Angola by 2018:

I. Prevention of infection;
II. Diagnosis, treatment and continuing care;
III. Creating a favorable ethical and legal environment;
IV. Multi-sectors integration and coordination;
V. Capacity Building and Resource Mobilization;
VI. Monitoring & evaluation and management of strategic information.

Each of these strategies has a set of specific objectives and service delivery areas. These areas involve interventions activities (see Operational Plan, p. 108 PEN 2015-2018).

TB National Strategic Plan (PEN TB 2013 – 2017)

The PEN TB 2013-2017 is a strategic instrument informed by the national health policy, to ensure the prevention and control of tuberculosis (TB) in the network of public and private services and involving partners and communities.

The Ministry of Health through the National Program leads the national response for Tuberculosis Control (NPTC). TB control is based mainly on the institutional implementation of DOTS (directly observed treatment) standardized and of short-term, increasing access to diagnosis and treatment, the control of MDR-TB, TB-HIV co-infection, nosocomial infection control in public health services and its expansion in the private sector through public-private partnerships to provide care to vulnerable groups with an emphasis on prisons, migrant populations and border areas.[15].

The strategies include the creation and expansion of community DOTS to improve the tracking and monitoring of patients in treatment, referral of contacts and respiratory symptoms to TB services, the active searching for drop-outs and the expansion of information activities about TB and the non-discrimination of sufferers.[16]

Goals, Objectives and Priority Program Areas

The National Strategic Plan for TB has been determined for 2013-2017. The general objective of PEN-TB 2013-2017 is to “Reduce morbidity and mortality from tuberculosis”,

[15] PEN-TB 2013-2017
[16] *PEN-TB 2013-2017*

based on the guidelines of the Stop TB Plan, the National Health Development Plan (PNDS) and the Millennium Development Goals (MDG).

The objectives of PEN-TB 2013-2017 are:

1. Detect 85% of estimated new cases of TBBK+;
2. Increase the proportion of new cases of TB having a minimum of 2 control sputum copies (all cases);
3. Achieve a treatment success rate of 85% among new cases of TB BK+;
4. Reduce the treatment drop-out rate from 14% to 5%;
5. Reduce TB mortality from 7,0% to 6,0%;
6. Increase the proportion of TB cases (all cases) tested for HIV from 25% to 95%.
7. Test with culture/TSA and treat TBMR 100% of diagnosed patients;
8. Establish DOTS-C in 100% of municipalities with high prevalence and in 50% of municipalities in the remaining 8 provinces;
9. Expand institutional DOTS in all health clinics of the eligible 161 municipalities;
10. Improve and standardize records in the TB information system in 100% of DOTS/UT/DAT and public-private partnership services (page 43-49 PEN-TB 2013-2017).

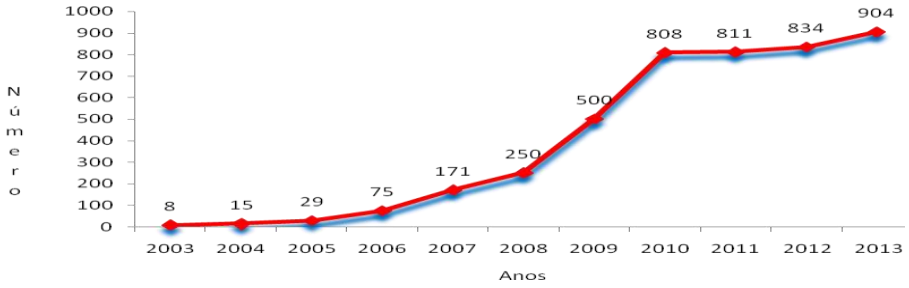
B.Implementation to date - Key Impact and outcome achievements

HIV/AIDS

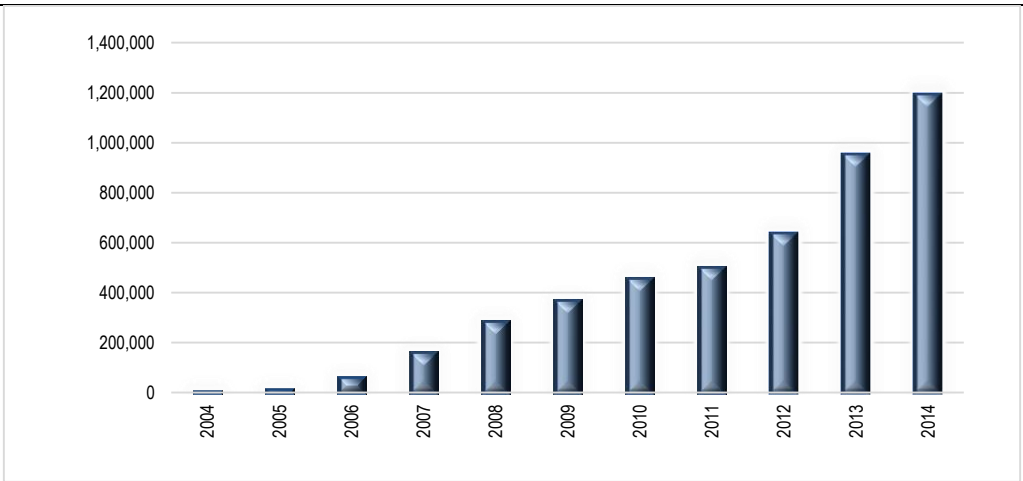
HTC achievements:

There has been expansion of the counseling and testing centres, to ensure universal access to prevention. By the end of 2013, there were 904 CT sites in the country (graph 16), consisting an integrated network with fixed CT/PMTCT and CT/ ART sites for adults and children, in all municipalities (818 sites were located in health clinics and 86 in mobile units by the end of 2013. By the end of 2013, there were 576 facilities providing antenatal care (ANC) representing 63.6% of counseling sites. Over time, the expansion of the CT service has been increasing, with an annual growth of more than 12% in recent years to 1068 by 2014. In 2014, a total of 1,191,972 adult men and women, and 26,877 children were counseled and tested an increase of 41.5% over the previous years.

Graph 16
Accumulated number of Counseling and Testing Sites Angola 2003-2013.



Graph...:. Number of people who underwent testing for HIV, from 2004 to 2014

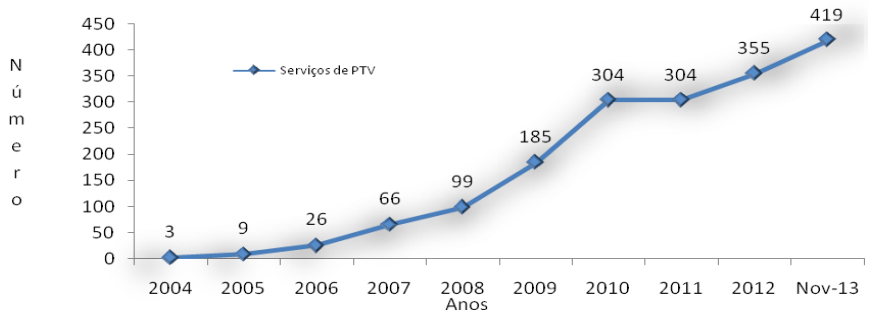


Source: INLS(2015)

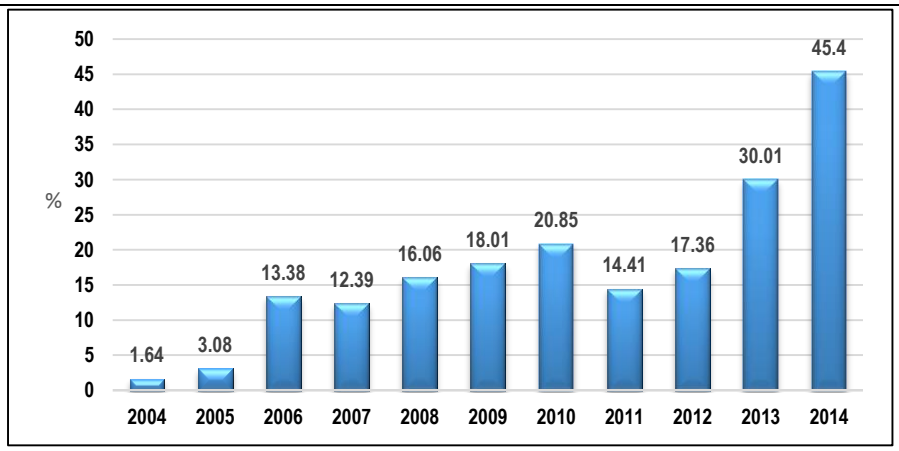
Prevention of Mother to Child Transmission of HIV (PMTCT):

PMTCT is a priority strategy of the national HIV program and was introduced in 2004 in all municipalities of Angola. Since 2007, the PMTCT program has been integrated in Reproductive Sexual Health Services, as part of Family Planning, Maternal Health, Antenatal care, maternity, postnatal, neonatal and infant health, which are the priority platform to reach women of childbearing age, pregnant women, their children and spouses. By 2014, there were 575 PMTCT sites for pregnant women in Angola (graph 17). 90% are part of the public network, while 10% are private. Since 2012, the country adopted the option B+ in tandem with WHO recommendations: all HIV positive pregnant women, after 14 weeks gestational age, regardless of CD4 cell count rate start ART for life. By 2014, a total 8709 (45%) HIV positive pregnant women received ARVs for PMTCT under option B+.(Graph 18)

Graph 17: Cumulative number of PMTCT sites per year in Angola, 2004 – 2013



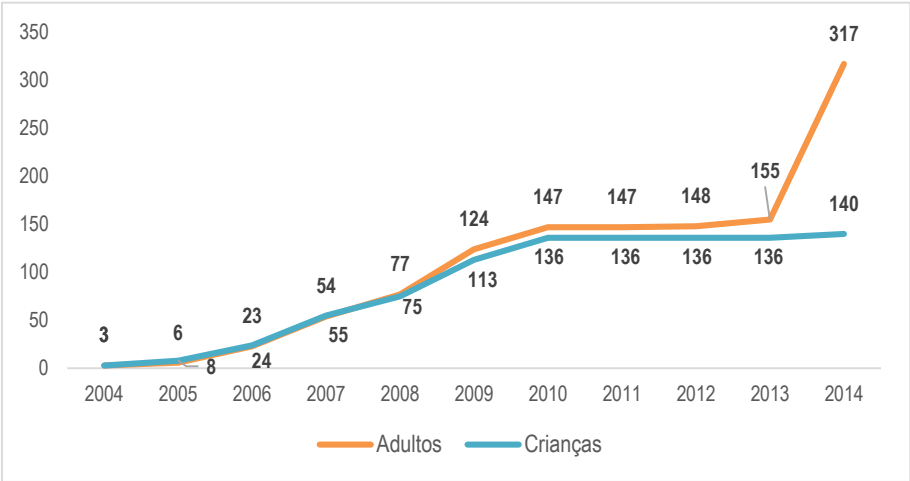
Graph 18 :Trends of PMTCT coverage among HIV positive pregnant women



HIV care and treatment:

Access to ART for adults, pregnant women and children was initiated in 2004 throughout the country, both in public and in private ART sites. The quality of ART services has been improved with a number of initiatives including the implementation of PIMA technology for CD4 cell count; the organization of referral services, prioritizing the care of more complex cases; the consolidation of early diagnosis by DPS; the conducting of advanced courses in the handling of CD4 cell count and the implementation of LBM genopath testing. In accordance with 2013 WHO guidelines, ART is initiated among adults and adolescents at ≤ 500 CD4 cell count. The Ministerial Decree of 2011 established the delegation of power and transfer of competencies for nurses to start ART in HIV positive pregnant women. All these interventions contribute to increasing access to ART[17]. By 2014, the number of ART sites has increased to 317 ART sites for Adults and 140 ART sites for children. (graph 19).

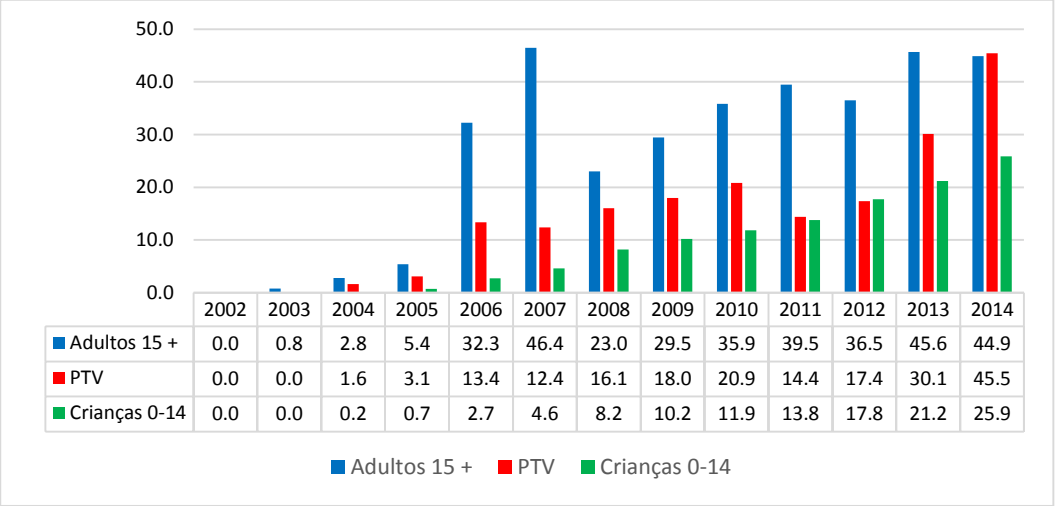
Graph 19 : Cumulative number of ART sites per year 2004-2014.



By 2014, a total 72,066 HIV positive adult men and women (45%) and 4,600 (13%) children were on ART (Graph 19).

Graph 19 : Coverage Antiretroviral Treatment in Adults, Children and PMTCT, 2004-2014

[17] V PEN-SIDA 2015-2018



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Adultos 15 +	0.0	0.8	2.8	5.4	32.3	46.4	23.0	29.5	35.9	39.5	36.5	45.6	44.9
PTV	0.0	0.0	1.6	3.1	13.4	12.4	16.1	18.0	20.9	14.4	17.4	30.1	45.5
Crianças 0-14	0.0	0.0	0.2	0.7	2.7	4.6	8.2	10.2	11.9	13.8	17.8	21.2	25.9

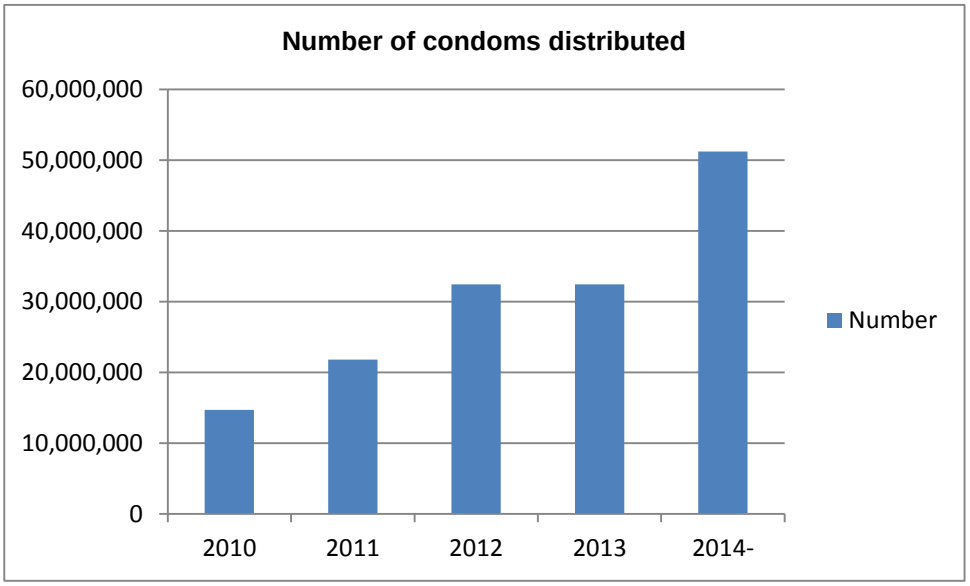
Collaborative TB-HIV services:

The program prioritized the control of co-infection of TB/HIV with the creation of a National Technical Group for TB/HIV; joint interventions for the training of human resources; supervisory training integrated in the AIDS and tuberculosis service provision. In 2013 , 48% of TB patients who had an HIV test result recorded in the TB register. In 2014, 27,699 people with TB were tested for HIV, and 2,827 found to be TB/HIV co-infected, which represents 10.2%. There is no data on number of PLHIV screened for TB or given IPT.

Condom use:

Massive distribution of condoms has been done all over the country and information about HIV and condom use has been spread out in civil society through social communication means, non-governmental organizations and people living with HIV/AIDS. Graph 20, below, shows the increasing trends for the distribution of male and female condoms between 2011-2014.

Graph..: Number of condoms distributed



Community based HIV and AIDS services:

The development of the National Communication Strategy constituted a pillar of interconnection with various sectors of civil society, including PLWHIV and AIDS organizations and community health agents. There have been several attempts from partners to establish a community health workforce, known as Community Health Agents (ACS) in different Provinces. There is recognition that the disease programmes have used ACS successfully for HIV counselling and testing, and TB DOTS.

In 2010 the first Community DOTS project in the country was implemented in the provinces of Huambo and Bié with support from USAID and INLS expanded the training of community peers called Patients Trainers Helpers (PAF) integrated into primary health facilities. Experience has shown that the involvement of people living with HIV (PLHIV) was very helpful in the support of service providers linking health facilities to communities. Community based HIV/AIDS services have been proven to be essential for achieving improved health outcomes for HIV/AIDS diseases and TB. Community people living with HIV (PLHIV) and key population are in a better position to understand and address the needs of affected populations

Angola has submitted an HSS concept note with CSS has crosscutting modules. During the implementation of this TB/HIV grant, the major roles of the community health agents (ACS) will include: Early identification of clients in need of TB and HIV services including KPs, Pregnant mothers, adolescent and paediatric; Provide psychosocial Counselling and adherence support for TB and HIV clients particularly on Ant -TB and or ARVs medication; community mobilization and sensitization on TB and HIV prevention, stigma reduction to affected individual including HIV,TB and key population; mobilize community and Male involvement in ANC(PMTCT) services.

Other roles of the community agents will include: providing health information, education and promotion for prevention and uptake of TB and HIV services; creating linkages and referral with health facilities for TB and HIV/AIDS services, follow up, tracking and linking back the missed appointment and/or lost to follow up clients on care and treatment, TB, and PMTCT services.

Monitoring and Evaluation:

The program designated provincial M&E focal persons, established 36 sentinel sites, undertaking behavioral studies among vulnerable groups, the population in general, genotype studies, plus the implementation of the Health Information System, and access to databases for planning and decision making.

Leadership of the Multi-sectoral coordination of response:

The national response was achieved through leadership at the highest level, the Angolan Head of State; the existence of Decree Nº 1/03 created by the National Commission for the Fight Against AIDS and Endemic Diseases[18]; Law 8/04[19] with rights and obligations on HIV and AIDS; Decree nº 7/05 establishing INLS as regulatory body and implementer of HIV/AIDS control policies; the existence of a National Health Development Plan that guides the strategic lines in the fight against AIDS and other endemic diseases; a business committee involving national and international companies with comprehensive programs in the workplace; the involvement of MAPTSS and seven ministries[20] that address issues related to AIDS; ANASO involving NGOs and civil society organizations and PLWHIV. It

[18] ANEXO Nº 22 Decreto 1/03 criação da Comissão Nacional de LCS e grandes endemias, Angola 2003
[19] ANEXO Nº 23 Lei 8/04 Direitos e Obrigações sobre VIH e SIDA
[20] MAPTSS (Ministério de Administração Pública e Segurança Social); MED (Min Educação); MINARS (Min. Assistência e reinserção social; MINDEF (Min Defesa); MINFAMU (Min Família e da Mulher); MINIT (Min Interior); MINJUD (Min Juventude); MIN Saúde.

also includes the indicators contained in the Social Welfare Policy[21], the Plan to Reduce Maternal and Child Mortality, the Plan to Combat Poverty where the problem of HIV/AIDS, TB and major endemic diseases is a priority[22].

Tuberculosis

The first TB program financed by Global Fund was implemented From 2005 to 2010 (FG/R-4), with the aim of strengthening TB control activities in 11 provinces in Angola, bridging a gap that up until that point had been impossible to achieve. Between 2010 and 2012, the PNCT suffered from a lack of human and financial resources to sustain the activities. In late 2012, a second program was started through GF Round 9. Global Fund Round 9 was directed at the "Expansion and Improvement of Tuberculosis Diagnosis and Treatment Services in Angola (AGO-911-G05-T)" in 18 provinces. The general objective was to expand the network of quality DOTs services and TB treatment units, reinforcing the care of TB/HIV patients and vulnerable groups with community participation[23].

TB Case notifications:

The trend of notification of all forms of TB from 2007 to 2013 shows a progressive increase of cases of BK (-) and of retreatment and/or extra pulmonary cases, which indicates limited access to TB diagnosis through sputum smear microscopy; the network of UDT/UT still has problems as regards expansion, mainly because of a lack of human resources in the health services (graph 10)

TB Case diagnosis:

In 2013, 60,807 cases of TB in all forms were registered, this an increase of 11% compared to previous year[24]. Out of all reported cases, 35.6% were new smear-positive cases BK (+); 44.1% of cases were smear negative, 7.9% were extra pulmonary TB and 12.4% of cases were previously treated. The low detection rate of smear-positive case is explained by the inadequate number of microscopy laboratories representing currently 99 for a population of 21,267,300 inhabitants (21.9% of the population). By August 2015, OGE supported by World Bank, procured 18 LED microscopes and 18 new Olympus microscopes. GF-round 9 procured 24 LED microscopes totaling to 42 LED and 18 Olympus to distribute in the country, this will enable the creation of new UDT (with functional laboratories for sputum smear microscopy).

TB treatment success rate:

The trends of TB treatment success (2008 to 2013,) shows that the treatment success rate decreased from 71% in 2011 to 46% in 2012; the cure rate decreased from 70% in 2012 to 27.9% in 2013; Dropout rate was high throughout the period of analysis; the death rate remain stable with an average of 4.3% and finally the rate of failure to treatment that appeared quite high was in 2009 (9.8%) and further reduction by 2013.

TB/HIV Integration:

The control of TB/HIV co-infection was initiated on a continuous basis in 2011. In 2013, 40.2% of patients in TB treatment were tested for HIV with a positive rate of 12.8%. In 7 provinces the rate of reporting of TB/HIV co-infection was significant (K-Kubango, Cabinda, Luanda, Cunene, Lunda Norte, Uíge e Lunda Sul).

MDR-TB case detection and management:

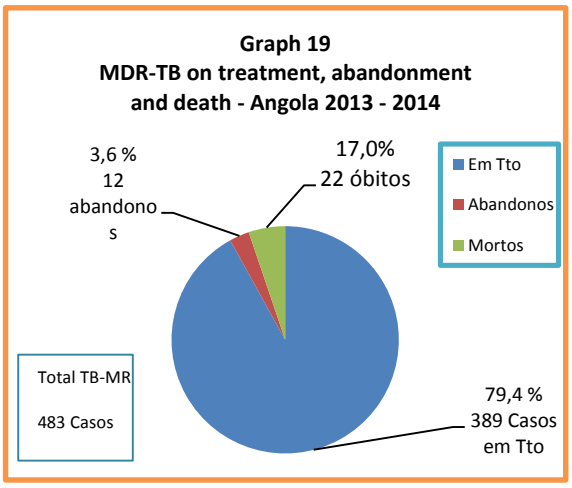
[21] ANEXO 24 Indicadores da Política de Bem-estar social
[22] V PEN-SIDA 2015-2018
[23] PEN-TB 2013-2017
[24] ANEXO 14 Relatório PNCT 2013, pag 14 e PEN TB 2013 - 2017

MDR-TB was first diagnosed in 2013. Out of the 423 cases that have been reported, 180 were in 2013, and 243 were in 2014. There are still major limitations in the diagnosis of MDR-TB as only three laboratories exist to undertake the testing. There is a network of 11 Hospitals Sanatoriums and 10 DATS with functions in the management of complicated TB and MDR-TB. Three laboratories are performing diagnosis of MDR-TB (Luanda, Benguela and Huambo). This network of services will be improved with the acquisition of 10 GeneXpert machines by the Government and 4 other through GF Round 9 and 4 through this grant application. Laboratory TB guidelines will be updated taking into account annual operational plans

MDR-TB treatment success rate:

From all patients detected with MDR-TB, 79% are currently in treatment, 17% died and 12% abandoned the treatment (see Graph 19, source PNCT).

Graph 19
MDR-TB on treatment, abandonment and death - Angola 2013 - 2014



PPP-TB:

The PNCT has a partnership with a number of NGOs, churches affiliated to INAR/ Ministry of Culture in the framework of Public-Private Partnership (PPP) in order to obtain information about reported cases and interventions regarding TB. Among the partners are IEIA, IEBA, IESA, Catholic Mission Cubal, Angolan Armed Forces, National Police, Chevron and CUAMM. In 2013, a total of 3,012 cases of TB treatment were reported, 86% among private providers, 10% in the Armed Forces and 4% in the National police[25].

Monitoring & Evaluation (M&E):

The Program has strengthened the monitoring and evaluation team, with responsibility to review the tools for calculation of indicators. It was found that the current calculation of the indicators used in previous years refers to the number of patients followed in treatment as denominator. From 2012 the program started using the number of reported cases of corresponding cohort as denominator, which is correct and universally used.

[25] *Relatório 2013 PNCT*

Current implementation of Round 9 (TB – GF) has supported the hiring of 10 TB M&E Focal Points in 10 provinces. They will strengthen the provincial team for better follow up of patients under treatment; they will try to improve success treatment, to promote active search of delinquents and also to improve TB/HIV and MDR-TB control. Conjunction of all these factors should contribute to the improvement of the indicators of the program of the TB and reporting.

Community TB interventions:

The NTP in its NSP 2013-2017 planned to improve its operational indicators, specifically success treatment rate by strengthening institutional DOTS and by implementing community DOTS.[26]. PNCT has been using community health agents (ACS) in community TB DOTS program in a number of provinces.

C. Limitations to Implementation across TB and HIV national programs and Lessons learned

- Integration with other health services: There is inadequate integration of HIV and TB prevention, care and treatment with other services. Furthermore, inadequate access to paediatric HIV treatment, which was 13% by December 2014, and low paediatric TB case detection, attributed in part by inadequate skilled personnel for treatment and limited diagnostic capacity to identify children with HIV and TB infection. There is inadequate follow-up of TB-HIV due to limited coordination between programs.
- Inadequate integration of HIV/TB prevention, care and treatment with other services. There are challenges in diagnosing TB-HIV at peripheral level / primary health care facility network with weak
- Gender inequality related challenges with women having relatively limited access to services. There is low involvement of women in decision making about their SRH and methods of prevention.
- Accessibility of free condoms is poor as they are available in health facilities only. Negative attitude on the use of condoms among sexually active populations.
- Inadequate HIV care and treatment for HIV-exposed infected and uninfected infants. There are challenges in the expansion of early HIV diagnosis among children
- Stigma and discrimination against PLHIV as well as Key affected people (KPs). The law on HIV/AIDS and rights of PLHIV is not adequately disseminated and fully operational.
- Stigma associated with TB/HIV co-infection; Patients with TB may not be free to seek medical services due to fear of being labelled as having HIV (self- stigma or stigma from other people)
- Small number of TB DOT centres (142) in comparison with HTC/PMTCT/ART sites (1,525), which makes for inter-facility referrals for collaborative TB/HIV services challenging . Need for strengthening inter-facility linkages and scale up of TB diagnosis and treatment sites to implement a strategy of “One Stop Shopping Centre” for TB/HIV services.
- Data availability & Data Quality challenges for TB/HIV program: The principle of “Three Ones” is not fully operationalized at INLS. The electronic system of data reporting is still poorly functioning. There is no recording and reporting system for KPs, as well as inadequate age disaggregation to establish and track service coverage among adolescents and youth. There is no recording and reporting system for TB screening and IPT amongst PLHIV. The country is planning to prioritize KP interventions through collaboration with implementing partners.
- Shortage of human resource to deliver HIV, TB and other health services: There are inadequacies in number/capacity of skilled staff and also with the infrastructure of the

[26] PEN-TB 2013 - 2017

health system in general to cope with increasing number of clients needing health and social welfare services.

- Inadequate coverage of services compared to population needs: Partial coverage of HIV and TB services in both public and private health facilities for instance, there is inadequate access to TB diagnosis and access to HIV Viral load testing and IED is still inadequate.
- There is no joint approach to supportive supervision, monitoring and evaluation between HIV/ TB programs. There is still inadequate systematic approach to TB/HIV integration and to monitoring the quality of care provided.
- There are large observed variations in TB case notifications regionally and over time. This is likely to represent variability in diagnostic capacity and in reporting capacity.
- Community health workers who help to reach TB/HIV patients with limited access to TB/HIV services do not have adequate incentives and enablers to perform their duties.
- Low community awareness on TB disease and service availability. There is limited awareness among provincial and municipal officials about the threat of TB for the health of the population;
- Where carried out, novel active case-finding activities yield significant increases in case notifications, which suggests that incident cases are insufficiently diagnosed (and transmission is ongoing).
- Probable under-diagnosis of TB in the elderly and possible under-diagnosis in children.
- Inadequate referral system for sputum specimens from peripheral laboratories to TB culture laboratories for culture and DST services.
- There are still major limitations in capacity for the diagnosis of MDR-TB as only three laboratories are performing diagnosis of MDR-TB (Luanda, Benguela and Huambo). Additionally, there are limitations in capacity in management of MDR-TB, as there exists 11 Hospitals Sanatoriums and 10 DATS with capacity in the management of complicated TB and MDR-TB. Three laboratories.

D. Linkages to the National health Strategy, including how implementation of this strategy impacts the relevant disease outcomes

TB and HIV/AIDS control are guided by the National Health Policy and the National Health Development Plan (PNDS) 2012-2025, which focuses on partnerships with the aim of achieving the Millennium Development Goals (MDGs) and increasing government health expenditure of 4.58% of total government expenditure. One of the priority strategies of the PNDS (PNDS April2014, Vol. 1, p.10) is the Prevention and control of endemic diseases, including HIV / AIDS, Malaria, Tuberculosis, Leprosy, Trypanosomiasis, Neglected Tropical Diseases and other communicable diseases; Furthermore, the national strategy focuses on reinforcing capacity in laboratories and in M&E. The following are the main areas of linkages of disease strategic plans and PNDS (2012-2015):

- In line with the plan for both the PNDS, PNCT and INLS have involved NGOs, FBOs, CBOs, and private-for-profit practitioners, to scale up TB and HIV services throughout the country.
- The V PEN SIDA (2015-2018) addresses the areas that are prioritized in the PNDS. Those includes HIV testing and counselling (HTC); ART; maximizing health sector contribution to HIV prevention; accelerating access and utilization of HIV/AIDS care and treatment services; scaling up integrated TB and HIV services; and scaling up STI control. These strategies aims at reducing HIV infection reduce HIV related mortality and reduce stigma and discrimination.
- PMTCT is addressing objectives of the HIV/AIDS disease in the PNDS. By reducing vertical HIV infection and also reducing HIV related morbidity and mortality by increasing access to lifelong ART through Option B+. HIV reporting is now integrated into the national HMIS, whereas efforts to improve data quality of HIV interventions are also expected to have spill over effect to all indicators within HMIS. PMTCT is also strategically placed in the RMNCH platform, further decentralizing ART to primary health clinics, while delivering ART in one stop RMNCH clinics. To increase access to

TB care and treatment, TB screening protocol has been developed for rollout in PMTCT/ART services.

- To respond to TB control under the PNDS, TB control services are fully integrated in the basic health services at provincial and municipal. Through the PEN-TB (2013-2017), PNCT supports health facilities by providing guidelines and training in TB and TB/HIV case management; laboratory quality assurance; provision of drugs and laboratory supplies; and supportive supervision.
- In line with PNDS and recognizing the importance of the Monitoring and Evaluation (M&E) System, the Tuberculosis Strategic Plan (PEN-TB 2013-2017), establishes HIS as a priority: "standardize the quality of TB information system, improving the monitoring and evaluation of actions at the several levels and areas of the program. The HIV / AIDS and Plan (VPEN 2015-2018) aims at strengthen the epidemiological surveillance and the information system in order to understand the epidemics behaviour and analyse the results achieved (p. 92). The PNDS envisages by 2016 to integrate the maternal, newborn and child health information system and have100% of the municipalities with functional Audit Committees for Maternal and Neonatal Deaths (PNDS, Vol. 2, p.136), including indicators on TB/HIV.
- The financial crisis has changed the economic landscape in Angola, and the indications are that the current situation will continue, without any reasonable likelihood of returning to the 2014 level for the foreseeable future. Therefore, the implementation of the PNDS will have impact on TB/HIV programs in 2016 and 2017. According to the budget by program presented in the PNDS (Vol. 3, p. 9), in the 2016 and 2017 more than US$ 10.2billion will be needed by the country to maintain its planned progress towards its health strategic objectives. The adjusted State budget allocated to health in 2015 is slightly more than US$2.3billion (76.4% the PNDS planned level) and, if we apply a conservative scenario projecting the average 6% inflation to the same amount over the next two years, the remaining gap will be US$7.9 Billion dollars. The total financial gap in PNDS programme area of Prevention and fight against diseases is estimated at USD 26,611,818 equivalent to 30% of the total gap. The impact of the adjusted state on TB/HIV programs performance in 2016 and 2017 will have implications on the targets to the achieved by the TB/HIV program that will consequently be adjusted downwards

E. Country processes for reviewing and revising the national disease strategic plan(s) including engagement of KPs.

In 2012, a review coordinated by WHO[27] was undertaken to assess the progress made in the PEN TB 2008-2012 and to inform the new PEN TB 2013-2017. The results showed major weaknesses and the need for greater investment in TB control in order to overcome the challenges of a comprehensive, quality program. Among the recommendations were:

- Technical assistance at all levels to ensure quality and timely management
- Increase access to high-quality diagnosis and treatment under direct observation, with access ensured through expanding the coverage of UDT/UT and a smear testing network; (iii) improve quality control of smear test diagnosis and implement culture and sensibility tests for the diagnosis of TB-MR;
- Strengthen the partnership for the control of TB/HIV, TB-MR and pulmonary health;
- Have a quality information system, prompt and with accessible data, as well as an agile medicine logistics without stock failure;
- Implement community DOTS as a reinforcement strategy in the control of drop-outs and for adherence to treatment and control of contacts;

[27] *ANEXO Nº 16 Resultados da avaliação do PEN 2007 – 2012 OMS 2012*

- Improve partnerships and coordination with public, private and civil society, including members of key populations[28].

As part of its multi-sector response, the PEN-AIDS embraces and involves a range of partners and stakeholders, who contribute to and adhere to the PEN-AIDS goals. Therefore, the revision of PEN-AIDS is participatory and includes all the multi-sector partners in the field of HIV and AIDS, including Key populations. The following are considered best practice with regard to the development and implementation of the PEN:

- The existence of a coordinating, regulatory and technical body, INLS that coordinates and integrates the work synergy of different levels and sectors, public, private and civil society, including the key population.
- The existence of a network of NGOs (ANASO) that works closely under national strategic lines.
- The existence of a business coalition that involves national and international companies, promoting AIDS programs in the workplace, with emphasis on the areas of prevention, treatment, care and support for people living with HIV/AIDS.
- The involvement of MAPTSS (Ministry of Public Administration, Employment and Social Security) in issues related to HIV/AIDS and workplace, and expressly prohibits HIV testing in the general framework of employment (Regulation 43/03)[29].
- The existence of HIV focal persons in the Ministry of Health, MAPTSS, Education, MINARS, the Ministry of the Interior, the Ministry of Defense (DSS/FAA), MINJUDE, MINFAMU[30].
- The United Nations have an HIV theme group, to coordinate synergies.
- The existence of Country Coordination Mechanism (CCM), under the government officials, national and international NGOs, representatives of people living with AIDS and other key population, the public and private business sector and the United Nations, to monitor the fight against AIDS malaria and TB.
- The existence of TWG on M&E with representatives from partners and a single harmonized M&E Framework and Plan for the collection of M& E data, and conducting specific studies (IBBSS) among key populations.[31].

In a coordinated manner, the various actors mentioned above, including key population are involved in a periodic review of the PEN-SIDA, annual report, mid-term review, and review at the end of the program.

[28] Relatório avaliação do PENTB 2008-2012. OMS 2012, em anexo
[29] *ANEXO Nº 27 Regulamento 43/03 de MAPTS sobre despistagem do VIH no local de trabalho*
[30] *ANEXO Nº 28 Relatório INLS 2013 e 2014*
[31] *ANEXO Nº 29 Plano de M&A do INLS*

1.3 Joint planning and alignment of TB and HIV Strategies, Policies and Interventions

In order to understand the **future** plans for joint TB and HIV planning and programming, briefly describe:

a. Plans for further alignment of the TB and HIV strategies, policies and interventions at different levels of the health systems and community systems. This should include a description of i) steps for the improvement of coverage and quality of services, ii) opportunities for joint implementation of crosscutting activities, and iii) expected efficiencies that will result from this joint implementation.

b. The barriers that need to be addressed in this alignment process.

2-4 PAGES SUGGESTED

A. Plans for further alignment of the TB and HIV strategies, policies and interventions at different levels of the health systems and community systems.

i) Steps for the improvement of coverage and quality of services

The National Office of Public Health (DNSP), the National Tuberculosis Control Program (PNCT) and the National Institute for the Fight Against AIDS (INLS) conducted an analysis to identify key interventions to enhance control of TB/HIV co-infection at a variety of levels (page 9 Collaborative Plan for TB/HIV "annexe1"). These interventions fall within the National Strategic Plan of the National Institute for the Fight Against AIDS 2014 - 2018 (PEN-HIV), the National Strategic Plan for Control of TB 2013 – 2017 (PEN-TB), the National Health Development Plan 2012 – 2021 (PNDS), and are articulated in the Collaborative Plan for TB/HIV, as follows:

- *Strengthening synergies between TB and AIDS programs to control TB/HIV co-infection at national and provincial level, through*
  (a) Coordination of effort and national response capacity to control TB/HIV co-infection, through the reactivation of the National and Provincial Committee for the control of TB/HIV co-infection;
  (b) Improve the technical capacity of the TB and AIDS network to ensure quality in the management of co-infection; joint planning of a Collaborative Plan with integrated standards and human resource training will be promoted;
  (c) Epidemiological surveillance with standardized indicators within a reliable information system and a single monitoring system for Monitoring and Evaluation of TB/HIV co-infection.
- *Institutional Capacity for the management of TB/HIV***:** There is a major commitment of both programs to improve the management of TB/HIV co-infection. Analyzing the programs one can see that the TB program has guidelines and tools, and there is a resolute leadership of MINSA for the control of TB. The health systems organization offers an opportunity to expand the network of TB/HIV sites at municipal level. However, there are barriers to be overcome, such as the reduction of number of patients who default on treatment, improving cure rates and treatment success rate, improving the information system with timely data, ensuring the logistics of medicine delivery and increasing greater involvement of partners and the community. The AIDS program has institutional capacity at provincial and municipal levels, trained staff in all provinces, a broad and well-structured network of services, priority issues in public policy, an appropriate annual budget from GOA that corresponds to

approximately 40% of national needs, with an informed population that facilitates the management of the disease among vulnerable groups and populations.

- *Reduction of the TB burden among people with HIV/AIDS, through key interventions***:**
  (i) Reinforcing the coordination of TB/AIDS services for the early diagnosis and supervised treatment of TB amongst PLHIV with co-infection. Organization of the community system and intensification of active searching for cases of TB among PLHIV;
  (ii) Ensuring timely prophylaxis with Isoniazid (PTI) to reduce the risk of co-infection among eligible PLHIV ;
  (iii) Enhancing patient contact control of those with TB/HIV co-infection.
- *Reduction of the HIV burden among people with TB***,** through:
  (i) Counseling and treatment of HIV among TB patients;
  (ii) Ensuring and monitoring treatment with ARVs, Isoniazid and Cotrimoxazole prophylaxis according to the guidelines for TB/HIV co-infection;
  (iii) Promoting home-based care for patients with TB/HIV co-infection.

Plans for further strengthening collaborations between INLS and PNCT include:

- *Establishment of multi-sector coordination mechanisms and community partnerships for the control of TB/HIV co-infection*, through
  (i) Participation in collaborative actions for the expansion of control over TB and HIV/AIDS in the workplace, public-private partnerships in agreement with national standards; priority will be given to the establishment of TB control in congregate settings (prisons \, nursing homes, children and adolescents);
  (ii) Information and communication aimed at reducing stigma and discrimination of TB and HIV/AIDS (page 10. TB/HIV Collaborative Plan "annex 3").
- *Integration or Collaborative Strategies* in order to implement joint actions, the PNCT and the National Institute for the Fight Against AIDS (INLS), analyzed the strategies that will contribute to an acceleration and enhancing of the collaboration between the two programs, with the following result:
- *Shared responsibility and greater synergy* between both programs to set policies and collaborative interventions to achieve the expected results with greater efficiency and an optimization of resources. This will be achieved through the development of an integrated plan for TB/HIV, the reactivation of the national and provincial committee for the control of TB/HIV and a revision and updating of standards for the control of co-infection.
- *Integration of services and universal access* to TB/HIV services, through meetings, training courses and integrated supervised training to reinforce the capacity of the staff and improve services at the different levels.
- *Defaulter tracing* in order to improve adherence to treatment, cure and treatment success of TB. A major challenge is to develop community DOTs, mainly to promote adherence to TB/HIV treatment in both programs, and support the expansion of information about the prevention, home care and nutritional care in the community.
- *Quality and accuracy of information*, with a prompt system of reporting and collecting information, assuring quality data, data analysis to inform decision-making. The challenge is to promote different levels of data sharing for timely decision-making.
- *Multi-sectoral and community partnership coordination***,** developing coordinated activities that enable the harmonization efforts of public-private partnerships, in order to have a viable unified, timely and consistent response that facilitates the interaction between the TB/HIV services sites and the community;

- *Single monitoring and evaluation;* through an epidemiological surveillance system and planning based on priorities and expected results, avoiding duplication of efforts, taking into account measurable and realistic indicators, and a computerized information system that is agile and accurate (page19. TB/HIV Collaborative Plan "annex 3").

ii) Opportunities for joint implementation of cross cutting activities

Integration of TB and HIV services will potentially provide opportunities for the joint implementation of crosscutting activities. Such activities may include joint capacity building, training and supervision; one stop TB and HIV diagnostic services and service delivery; joint resource mobilisation and reporting; joint procurement and supply of medicines and TB/HIV commodities; and harmonised health information systems. Alignment of the two programmes presents a unique opportunity to strengthen joint implementation of cross cutting TB and HIV interventions including:

a) *Human resource:* In facilities where both TB and HIV services are offered, the same health personnel will be able to provide both services, hence optimizing services delivery. Provision of joint TB and HIV services under one roof enhance programs performance, reduces lost to follow up and leverages human resource for HIV and TB.

b) *Diagnostic services:* The alignment of diagnostic services for TB and HIV will enable laboratories especially in lower level health facilities that are housed in the same buildings and are managed by the same person, to effectively offer services in a timely manner, hence reduce clients' burden of accessing these services from different points or different time. At the national and reference levels, similar platforms can be used, especially for molecular diagnosis and treatment monitoring.

c) *Procurement and supply chain management:* Procurement of both HIV and TB medicines and commodities can be are managed by single supply chain again, hence leveraging cost reduction through bulk procurement and shipping. This creates a room for further collaboration in HIV and TB services at the level of quantification and down the whole SCM cascade. .

d) *Supportive supervision visits:* Joint supervisory visits will enable joint provision of appropriate technical assistance that is geared to improve quality of lives of people affected by TB and HIV and identifying challenges that requires joint solutions. This will reduce the time that health facility staffs spend on two programs separately that would be used for attending hospital services and other program needs.

e) The joint TB/HIV Global Fund Grant will further consolidate joint programme management and subsequently avail an opportunity for joint monitoring and implementation of interventions across the two programmes.

iii) Expected efficiencies that will result from this joint implementation.

It is implicit that joint programme implementation (joint planning, reviews, supervision, procurement and M&E) between PNCT and INLS is likely to improve efficiencies in the management of scarce health resources. Specifically, there will be minimization on transactional and human resource costs for the targeted outputs. Savings made will be used to fill other service provision gaps. From the community and patients' perspective joint provision of health services, for example ART in TB clinics under one roof reduces the unnecessary clinic visits and transportation costs potentially contributing to low default rates and programme sustainability.

B. Barriers that need to be addressed in this alignment process

i). *Overlapping strategic plans:* PNCT and INLS have separate strategic plans that have overlapping periods of implementation and different expiry dates. Therefore synchronization of interventions and implementation that are essentially managed from different programme management platforms poses a challenge. To effectively permit joint monitoring and programme reviews, there is need in future to consider harmonization of TB and HIV strategic plans.

ii). *Vertical programme implementation:* Vertical implementation of HIV and TB programs dates back to the establishment of the respective programmes and reservations for potential structural re-organization could be inevitable. Alignment of interventions will

therefore require significant efforts from programmes, time and sustained political will from the senior management.

iii) Resistance to change: Alignment processes will imply new ways of programme management and the implementation is likely to be associated with unverified uncertainties of potential dilution of core successes from each programme. Thorough and elaborate plans for staff orientation need to be put in place in order to address staff concerns, misperceptions and resistance to change.

iv). *Levels and coverage of services:* Levels of service provision for TB and HIV services are not necessarily the same. Whereas both TB and HIV services are decentralized to municipal levels than HIV, there is a need for attention to be paid to the most effective areas for integration.

v). *Funding:* Alignment process will involve investments in integrated guidelines, training manuals and M&E tools and systems. Furthermore, investments will target capacity building for health workers in health facilities and at community level. Funding for such joint investments will be required to ensure that smooth alignment of the two programs and services.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources that are insufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the TB and HIV national programs and how this funding request fits within these, briefly describe:

a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).

b. How the proposed Global Fund investment has leveraged other donor resources.

c. For program areas that have significant funding gaps, planned actions to address these gaps.

2-3 PAGES SUGGESTED

A. Funding availability for the disease programs

Angola has one of the fastest growing economies in sub-Saharan Africa and, in 2012, was classified as a country of medium-high income. Angola has still to recover from the impact of decades of war, so the primary focus of national development plans is on the development of infrastructures, including strengthening the delivery of basic social services.

Financing of the TB and HIV programs in Angola is heavily dependent on domestic resources with government contribution more than 60% for the HIV program and 100% of the TB program budgets. Major donors for the HIV/TB program include the World bank, US Government/PEPFAR, Global Fund and 'One-UN". Angola's economy remains heavily dependent on the oil sector, making it very vulnerable to global market fluctuations. In 2013, aid represented 0.5% of government revenues mainly from oil. For 2015, government revenues are expected to fall due to a drop in oil revenue, and this will have a serious effect on health programs. Angola has made considerable progress in increasing expenditure on health, reaching 5.59% (2014), with the response to HIV/TB in the country being financed largely by domestic resources**.**

Table 2, below, provides a summary of a full Financial gap analysis for TB/HIV programs covered by GOA OGE and other sources. It can be seen from this summary that none of the programmes has adequate resources. There is a significant funding gaps for both TB and HIV programs, and the health system in general which cannot be met by the GFATM allocation. Therefore, the CCM and all the partners reached a consensus on priority modules and their targets for the TB/HIV concept note within allocation amount and considered the above allocation in light of the recent financial crisis to meet the funding gap.

Table: 2: Financial gap analysis

SOURCE	TOTAL			
Summary: HIV gap	**2016**	**2017**	**2016/2017**	**% of available**
TOTAL NSP BUDGET	170,497,002	187,823,879	358,320,881	
OGE	30,000,000	30,000,000	60,000,000	57.7
PEPFAR	17,500,000	17,500,000	35,000,000	33.7
ONE-UN	2,000,000	2,000,000	4,000,000	3.8
WORLD BANK	5,000,000	0	5,000,000	4.8
TOTAL FUNDING AVAILABLE	54,500,000	49,500,000	104,000,000	100.0
FINANCIAL GAP	**59,500,000**	**49,500,000**	**109,000,000**	
Summary: TB gap	**2016**	**2017**	**TOTAL FOR 2016/2-17**	**% of available**
TOTAL PEN-TB BUDGET	14,027,400	12,840,900	26,868,300	
OGE	6,000,000	6,000,000	12,000,000	100
PEPFAR	0	0	0	0
ONE-UN	0	0	0	0
WORLD BANK	0	0	0	0
TOTAL FUNDING AVAILABLE	6,000,000	6,000,000	12,000,000	100
FINANCIAL GAP	**8,027,400**	**6,840,900**	**14,868,300**	

Source: INLS/PNCT

B. How the proposed Global Fund investments have led to resources from other donors

The investment of Global Fund will catalyze other funds from other donors. To leverage Global Fund resources, the World bank has committed funds amounting to USD 5 million for each of the years 2016 and 2017 for the purchase of HIV test Kits and ARV; USG/PEPEFAR has committed USD 12.5 million for interventions among key population; while the UN Joint Team has committed USD 2 million towards Technical assistance, PMTCT and Condom procurement. The country plans to develop coordination mechanisms including the Partnership Chart and Agencies table. These coordination mechanisms will promote dialogue and transparency between donors so that all partners will be aware of the program areas with funding gaps. The coordination will prevent duplication of resources while other partners will be encouraged to meet the uncovered needs associated with TB, TB/HIV and HIV/AIDS interventions.

C. For programmatic areas with funding gaps, the actions planned to address these shortcomings

It is not anticipated that the GOA can completely fund the entire gap and as such other resource options will need to be explored. A more robust sustainable financing strategy becomes all the more important in light of this scenario.

To address the shortcomings of funding, the country plans to strengthen advocacy at different levels of the system. Advocacy activities will be carried out in order to strengthen partnerships between public and private sectors. Efforts will also be directed to provincial governments to heighten decentralized political involvement. Multi-sectoral coordination and community partnerships will be the main strategies to converge efforts toward a unified and sustained response. Communities will be sensitized and decentralized services will be expanded.

The GOA has also been working very closely with the Private sector and Civil Society Organization for resource mobilization. Resource mobilization among these has been undertaken with some degree of success at mobilizing resources, for example as part of Corporate Social Responsibility (CRS) of oil companies, among others.

As an option, in this application, the country is also requesting for an above allocation incentive funding for high impact interventions of which prevention programs among key and vulnerable population (MSM & TGs, FWS and clients, truck drivers and miners, adolescents and youth) and TB/HIV collaborative activities have been prioritized. If approved, the incentive funding will help sustain the TB/HIV interventions.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. For TB and HIV, indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess compliance	X☐Yes ☐ No	
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	X☐Yes ☐ No	
iii. Increasing government contribution to disease program	X☐Yes ☐ No	

b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

2-3 PAGES SUGGESTED

National TB program

Within the duration of the implementation period for this application, the Government of Angola (GOA) has projected to contribute $6,000,000 in 2016 and $ 6,000,000 in 2017 respectively to the National TB program. These investments are expected to count towards the willingness to pay allocation from the Global Fund. These funds are pooled resources from the Government own sources and expected to be utilized amongst others for the purposes of Human resources for health, health system maintenance, procurement of drugs and pharmaceuticals, and supporting laboratories interventions. Illustrative investments in TB program are listed in the table below:

Table 2: Investment allocation for the TB program

Activities	2013		2014	
	Public Budget	GF-R9 SR1/SR2	Public Budget	GF-R9 SR1/SR2
Drugs, reagents and lab supplies	100% purchase and logistics in provinces		100% purchase and logistics in provinces	
Human resources, Procurement	Government supports 100% of HR at central, provincial and municipal level of laboratory network	70% of HR at the central level, supports supervisors at provincial level	Government supports 100% of HR at central, provincial and municipal level of laboratory network	70% of HR at the central level, supports supervisors at provincial level
Administrative expenses, IEC materials	50% of national support	50% of national support	50% of national support	50% of national support
Trainings, supervisions and meetings	10% of national support	70% of national support	40% of national support	50% of national support
IEC materials	60% of support	20% of support	60% of support	20% of support
Maintenance, Office furniture	40% of support	20% of support	40% of support	20% of support

National HIV Program

Within the duration of the implementation period for this application, the government of Angola has projected to contribute $30,000,000 (2016) and $30,000,000 in 2017 respectively to the National HIV program. These estimates are derived from analysis based on recent budget revision after the oil crisis.

These investments are expected to count towards the willingness to pay allocation from the Global Fund. These funds are earmarked for staff salaries, purchase of HIV test kits, ARV drugs, prevention interventions and commodities; other systems strengthening investments like renovation of facilities; printing of HMIS tools, trainings, and program coordination amongst others. These contributions are complemented by funding from other sources and have been factored into the gap analysis tables for priority modules attached to this concept note.

Assessment of the completeness and reliability of financial data

The financial data are sourced from Public Expenditure reviews and budget estimates from official documents of government of Angola. Operative assumptions are annual increases in the national health budget estimated to correlate with projected annual GDP growth. Adjustments were made in consideration of the impact of current oil crisis on state budgets.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and outlines how the investment is strategically targeted to achieve greater impact on the diseases and health systems. While the investments for both the HIV and TB programs should be described, the applicant should also provide information on the expected impact and efficiencies achieved from planned joint programming for the two diseases including cross-cutting health systems strengthening as relevant.

3.1 Programmatic Gap Analysis

A programmatic gap analysis should be conducted for the six to twelve priority modules within the applicant's funding request. These modules should appropriately reflect the two separate disease programs in addition to cross-cutting modules for both programs such as Health System and Community Systems Strengthening.

Complete a programmatic gap table (Table 2) for the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps in the narrative section below.

2-4 PAGES SUGGESTED – ***only for modules that are difficult to quantify***

Programmatic gap analysis tables have been completed for the quantifiable priority modules. These have been attached to this concept note narrative. For the others, a narrative is provided below to describe the programmatic gaps.

Module: Program Management

The Government in collaboration with development partners has established Coordination structures for state and non-state actors at all levels to coordinate implementation of HIV and TB programs. At the National level, the INLS and PCNT are responsible for coordination, oversight and control of Government business. The INLS handles all sectoral collaboration efforts including the National response to HIV and AIDS and is part of the CCM, which addresses other multi sectoral related diseases. The Joint TWG for HIV and AIDS provides a platform for collaboration with the TB program (PNCT)). The Ministry of Health (MINSA) coordinates the overall national response for HIV, TB and Malaria through respective disease programs. Through Global Fund support the INLS and PNCT at the central level were strengthened to implement the national TB and HIV responses.

At the regional level, the Provincial Health Management Team (PHMT) is responsible for all health services in the region including HIV, TB and Malaria. At municipality level, the Municipal Health Management Team (MHMT) has similar responsibility as the regional level at municipal councils and community based services. The ANASO Steering Committee coordinates the civil society and NGO response to HIV/TB.

Existing Gap:

- Limited integration of TB and HIV programs at National and sub-national levels.
- Overlapping roles and responsibilities between health sector and multi-sectoral coordination of the HIV/AIDS and TB, in the phase of changing epidemics.

- Inadequate coordination capacity at national and sub-national levels including umbrella networks, to advocate for domestic resource mobilisation and sustainability of the TB and HIV program.
- Inadequate planning, monitoring, supervision and coordination capacity within sub-national structures in executing TB and HIV programs;

Module: Monitoring and Evaluation

Angola is implementing HIS in collaboration with development partners for the health sector. GEPE is the body delegated by the National Statistics Institute (INE) for the collection, analysis and production of health statistical information. In this context, GEPE receives the data, analyses and reports to the INE every three months (Epidemiological Profile of Angola. Angola Disease Health Regulation and Immunization Program).

The joint concept note TB/ HIV identified some non quantifiable gaps related to monitoring and evaluation and program management. Many of gaps will be taken into account in the health system strengthening concept note. Nonetheless, a brief presentation of the gaps is presented in this CN particularly those that directly impact on implementation of TB/HIV programs.

Despite Government and various partners efforts during the implementation of GF- Round 9, the financial and human resources to support M&E activities are very limited at all levels of the system. As a unique HIS is not in place, each program or service has its own sub-system for data collection and report writing. Information is fragmented and scattered across the programs. The Ministry of Health and Programs are therefore unable to properly understand or monitor the overall progress achieved in most of the performance indicators. It is also unable to review strategic information that would inform decision making.

There are several gaps that exist in the M&E systems for TB and HIV/AIDS. The M&E module of this concept note aims at bridging these gaps by aligning the M&E in these programs with the National HIS and ensuring proper M&E of the proposed interventions under this application through quality assured and timely reported indicators. HIV and TB information systems for both medical and non medical services will also be strengthened. The specific gaps in M&E for TB and HIV include:

System issues:

- Inadequate number of skilled M&E personnel at national and sub-national levels.
- Inadequate outcome and impact studies among general and key populations to inform programming
-

Reporting and data usage:

- Lack of age-disaggregation of key HIV and TB indicators (e.g. for adolescents) in reporting systems
- Low utilization of data generated from health-related TB and HIV routine recording and reporting system by stakeholders at sub-national levels for planning and programming.
- Lack of linkage of HTC and HIV Care Patient monitoring system for monitoring of the treatment cascade.

Data quality:

- Suboptimal quality (incompleteness, inaccuracy and timeliness) of surveillance data for TB and HIV at province and municipality levels.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request for TB and HIV, including both the proposed investment of the allocation amount and the request above this amount. Include the specific elements related to joint programming such as health systems and community systems strengthening. Describe how the request addresses the gaps and constraints described in sections 1, 2 and 3.1.If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

2-4 PAGES SUGGESTED

Strategic Overview of Application:

Angolan Context

The country context provided in Section 1 depicts improvements in prevention, care and treatment for both TB and HIV, but attainment of national targets has been constrained by limited funding, among other factors.

There had been a decline in domestic revenues since 2014 as a result of the oil crisis, leading to recognition that we must maximize the impact of the resources we have, demonstrate these impacts explicitly, and utilise that as a success to mobilize new resources for both the TB and HIV programmes. Clearly we must do better than we are doing now if we are to achieve the end of AIDS by 2030 and control TB. The country has gone through a strategic development process to inform the priorities for this concept note. The overarching strategies are noted below.

Strategies:

1. **Prioritization of high need - high impact interventions:** The limited resource envelop required that the country go through a prioritization process on what modules to invest in. With reference to the results of an investment case scenario for Angola, the country chose the best option. In this scenario, most cost effective interventions are scaled up (ART, PMTCT, KPs, TB/HIV). This approach also considered the cost-effectiveness ratios of these interventions as depicted in the report.

2. **Improving TB and HIV joint programming:** TB/HIV activities are also being prioritized in this application. Specific joint programming activities have been identified for roll out and will include integration of the HMIS systems, joint supervisory visits; joint planning and training activities, co-location of ART, TB and RMNCH services (one stop shop) and a gradual expansion of the basic package of services for KPs to include both HIV and TB screening amongst other services on offer. Special coordination meetings are planned including joint program reviews. Efforts at leveraging TB and HIV resources at facility level will be initiated. Prioritization of regions with high burden of TB/HIV co-infection is also a key component of this strategy.

3. **Ensuring commodity security to sustain gains in the ART/PMTCT and TB programs:** Angola is committed to sustain the gains made in reducing morbidity and mortality related to the HIV ART program; the reduction of new HIV and TB infections from the prevention programs, as well as honouring ethical commitment to PLHIVs and diagnosed TB patients by ensuring continuity of treatment services. This is being achieved through a proactive effort to ensure commodity security for a defined period to forestall an imminent drug stock out. In view of this, OGE has made a financial commitment to sustain the current coverage of 17,000 new people who need ARVs annually to facilitate procurement of commodities (ARV drugs, test kits and laboratory consumables) to ensure treatment continuity for 2016 and 2017. These will be complimented by funding from the World Bank to reach the targets. GOA is also committing 6 million USD annually for the TB program to extend coverage for 2016 and. Other commodity security initiatives include strengthening the procurement and supply

chain management systems that have been requested through the HSS concept submitted by Angola.

4. **Resource leveraging for efficiencies:** Effective leveraging of resources from other donors and partners in the country is another key strategy in this application. Specific consideration has been given to the resources expected from the GOA, World Bank, USG-PEPFAR, One-UN and this application has been mapped to ensure complementarity of the resources. While a significant portion of the GF allocation funds will be channelled towards commodity procurements, the OGEG and USG has committed significant amount of resources towards other service delivery components including Prevention programs for general population, programs for KPs, TB/HIV and TB modules, and cross cutting HSS modules. These considerations were made in arriving at uniform unit costs that helped translate the funding commitments into potential number of persons reached with services. This also helped bring to fore the gaps in the implementation of the National strategic plans and related cost implications.

5. **Request for Incentive Funding for Key and under-resourced Interventions:** Another strategy is the exploration of the incentive funding window to request for funding support to bridge the notable gaps in the two disease programs. The country in this application has earmarked specific investment areas considered as strategic and of high impact and put in requests for funding above the current allocation. It is important to note that there are potential consequences of failure to secure resources for interventions earmarked for funding using the above allocation option. Due to new infections and survival on antiretroviral therapy, the number of people needing ART continues to grow in Angola. There remains an enormous unmet need for treatment and a need for a sustained and expanded response. Not being able to mobilize incentive funding would serious undermine both TB and HIV programmes.

6. **Prioritization of KPs and other vulnerable groups:** Addressing needs for KPs is critical to the national response as they drive the HIV/TB epidemic. The HIV program in line with the epidemiology has identified FSWs, MSM and Transgender and Miners and Truck drivers as population groups with elevated HIV prevalence rates as key and vulnerable populations to be targeted by the HIV program. The intent is to leverage existing investments by other partners including PEPFAR to significantly increase service coverage to these populations. The TB program has prioritized prisoners in particular for reasons of their vulnerability and relative limited access to services. Gender considerations have also been made to improve service access to young women 15-24 years and married women who have been noted to be more vulnerable to HIV infection. The prevention for adolescents and youth module is specifically targeted at these groups, including adolescents and young people. There is a plan in this grant to train health workers and ACS to meet the specific needs of KPs.

7. **Prioritisation of Truck drivers:** Angola is part of two major trans African corridors. The first runs from North to South, linking Tripoli in Libya with Cape Town in South Africa. The second one, running from East to West, links Beira in Mozambique with Lobito in Angola. There are 51, 429 Km of roads in Angola and most of freight in Angola is transported by trucks.

   Transport sector workers are more likely to acquire the HIV infection as workers in 'low-risk' occupations. Transport workers could also serve as bridge populations linking with the general population. There are specific factors that make truck drivers especially vulnerable to HIV risks:

- Frequent overnight stays away from homes and families
- Hard working conditions with long hours, high risk of injuries and elevated stress levels

- Long waiting periods in ports, truck stops and border crossing where the availability of commercial and transactional sex increases the risk of infections
- Multiple “fixed” partners along the regular routes or at truck stops
- Limited availability of health clinics, HIV testing sites and mobile clinics at the truck stops
- Low condom availability at the truck stops
- Higher alcohol consumption during the wait periods and lack of social controls
- Lack of knowledge and low risk perceptions about HIV transmission and HIV preventative behaviors

In 2013, PSI conducted a research among 1645 truck drivers in the provinces of Luanda, Benguela, Cunene, Huila and Huambo. The results showed that only 44% of all the respondents had an HIV test at least once in their life. However, only 1,5% of the respondents had an HIV test in the 12 months preceding the survey. 20% of the respondents had STI symptoms in the last 12 months but only 68% of those consulted a specialist in the last STI episode. Though the reported condom use with commercial sex partners is comparatively high (80%), it drops significantly with occasional partners (62%) and spouses (31%).

According to the transportation police, the most widely used routes are Luanda – Moxico - Lundas, and Luanda- Lobito - Lubango - Cunene. The first stage that will precede the interventions will be mapping of the most frequented truck stops and hot spots on these routes.

Holistic set of interventions is needed to reduce the risk of HIV infection and encourage HIV testing and counseling among the truck drivers:

- Behaviour Change Communication (BCC) interventions to increase knowledge and motivate them change present unsafe behavioral practices and reduce their vulnerability

These interventions will happen at the truck stops on the main routes. These interventions are truck stops are particularly important for the truckers who are employed by small companies, which are difficult to reach through workplace programs, and self-employed truckers.

Behavior change communication interventions will include one-on-one and small group discussions and counseling sessions conducted by trained outreach workers. The outreach workers will also hand out HIV testing and counseling referral cards, condoms, informational leaflets and support phone numbers.

Peer educators among the truck drivers will be identified and trained in HIV prevention. A possibility to brand the peer educator truck with a sticker will be explored. The peer educators will engage their fellow drivers in conversations about safer behaviors during the rest hours at truck stops. The peer educators will also be able to provide fellow drivers will condoms, as well as referral to testing and treatment centers.

The secondary audience for the BCC interventions will be workers at the truck stops like café and hotel’s owners and small retailers. The goal of reaching the secondary audience it is to ensure that condoms, informational booklets and posters and HIV testing and counseling information are available on the truck stops and sites.

- Clinical interventions through establishing mobile clinic facilities at truck stops for HIV/STI testing and counseling, condoms and information services and organizing referrals to treatment

  As in the above, the main target of these interventions is to reach the self-employed truckers and the truckers from small companies, who cannot be HIV tested and counseled via workplace programs. Up to 3 mobile testing clinics will be established and their work hours will be communicated via outreach, referral cards and small billboards at the truck stops and en route. For the people who identified HIV positive at the mobile clinics the linkages will be made to treatment facilities so that the positive cases are followed. MHealth solution for referrals will be explored to facilitate the linkages to the treatment clinics.

- Market interventions to increase the availability of condoms at truck stops through non traditional outlets

  Condom availability and affordability is an important factor to increase its use. Oftentimes pharmacies are not available en route and at truck stopes so it is critical to ensure that the condoms are available at gas stations, small retailing kiosks and shops, hotels and guest houses. These retailers will be mapped and linked with the condom distributors.

- Structural interventions with the engagement of trucking companies to develop and operationalize workplace policies

  The big trucking companies may already have HIV prevention workplace policies but often times not enough effort is made to fully operationalize them. The Association of Truckers and Operators of Angola (Associacao de Camionistas e Operadores de Angola) will be involved in the advocacy efforts to reinforce the workplace HIV prevention, testing and treatment policies. The set of activities will include developing or revising the manual for HIV prevention, testing and treatment, training of key staff as master training; ensuring that HIV training is a mandatory part of induction training/refresher training for truckers. Organizing testing at workplace and facilitating linkages to treatment for the positive cases is also a critical part of the interventions at the workplace.

8. **Prioritisation of Miners:** As per beginning of 2016, the mining industry in Angola consisted only of mining for diamonds. While there are starting or ongoing investment in gold, copper, iron and phosphates mining, none of them has yet entered the production phase. The only functioning mines are diamond mines. About 7,000 miners work for the official mining companies. The organized diamond industry has own clinics for miners and their families.

   On the other side of the spectrum are the illegal diamond miners that work together in small groups scattered in the diamond provinces of Lunda Norte, Lunda Sul and Malange. Their number is difficult to estimate but could be up around 50,000. This is the group that is very vulnerable, because it not only lacks access to services and life skills, but due to the illegality of their trade tries to stay hidden from any public intervention.

The illegal mining workers will be the ones most targeted with the above intervention. There are small urban centers where illegal miners come to buy food and trade that can be used as basis for outreach.

The in-allocation will include the mapping of illegal mining population and their lifestyle, as well as targeted IEC and testing interventions in the urban centres near to the illegal mining areas.

The above allocation will include 2 mobile testing trucks operational in areas where illegal mining is prevalent, related health products and operational expenditures, work of 30 activists, training and supervision for nurses in health centers, health products/equipment to test and treat STIs, customized IEC for this target group, condom distribution and subsidized condom sale.

The project will in the in-allocation and above allocation work with the clinics to broaden the HIV and STI testing and life skills of the regular mining workers.

9. Prioritisation of youth:

- **Behaviour change communication activity among youth**

To increase safer behaviours among youth it is essential to engage with them and their culture in order to make condoms and HIV relevant for them. Angolan youth currently has a popular music movement *Kuduru* with many youths following their local *Kuduristas*, who very often sing about things important to youth. We will work to identify local *Kuduristas* who will endorse promoting safer behaviours, and *Kuduristas* will be central to the following activities:

- Experiential marketing events

Experiential at markets and hot spots to communicate directly with youth. These events will be conducted every Friday afternoon in several locations. Initial research shows that these events could be more effective if they have a broader discussion with the youth that includes sexual and reproductive health topics, gender relationship, and condom use and HIV. Fridays are selected because Angolan youth starts their partying weekend on Friday afternoons, and is often engaged in the risky sexual behaviours including casual or commercial sex. It is critical then to engage the youth at the time before the risky acts to encourage safer behaviours. Popular youth culture artists (Kuduristas) will be involved to make the events popular among youth.

- Mass media events with radio shows and radio spots.

In order to increase the coverage of the experiential marketing events the radio shows will follow the events and directly broadcast them to reach the youth not attending the events. Live events with participation from popular radio and street DJs, Kuduristas and youth itself will likely increase the popularity of the radio talk shows. The work will be done in bars, clubs and other locations frequented by youth to encourage them to put the shows on air so that the audience could hear them. Additionally several radio spots will be created and placed on several radio stations that talk about condom use, safer behaviours and HIV

- Social media

Research among Angolan youth shows that Facebook and You Tube are two most used and influential mass media sources. The Facebook page will be created to follow the experiential marketing events. Additionally the page will host live discussions, doctor and counsellor online consultations, and live chats with role models to actively engage youth in the conversation about sexual health, condom us, gender relationship and HIV. The most interesting experiential marketing events will be posted on You Tube for youth to see and comment on. Additionally, Kuduristas, who receive millions of views from Angolan youth on You Tube, will be involved in messaging about safer behaviours and condom use.

- **School Clubs and Youth Centres**

School clubs and Youth Centres are a great way to assemble youth for extracurricular activities. This clubs, which would take once a week, will target youth from 7th Grade to High school students. Some youth will be trained to become peer educators and club leaders. The clubs will have a list of topics and activities to be conducted per session. The activities can include but are not limited to: condoms distribution, games, competitions, plays, or watch a movie about HIV, informative board and news on HIV, SRH, etc. Each school involved should have a small place equipped with pamphlets and other source of information for youth in Schools.

- **Church groups**

Churches and church support groups also play a very important role in shaping youth's behaviours and attitudes. Leaders of these groups will be trained in HIV prevention so that they can have conversations about it with the group goers. Referral cards to nearby public health facilities will be also distributed to the church groups to encourage HIV testing. Church support groups will also be critical to provide psychological support to HIV positive people and encourage starting treatment and adhering to it.

- **HIV testing and referrals to treatment**

In Professional Education centres and Universities HIV the trained nurses and counsellors from the nearby public centres will organize testing monthly. The referral for treatment of positive cases will be essential component of these activities. To have a high testing uptake ensuring confidentiality of the testing results will be paramount to achieve. Referral cards, posters and leaflets about HIV testing centres in the catchment areas of Universities and education centres.

- **mHealth**

mHealth approach will be piloted in order to increase adherence to ARV treatment

From selected public centres, clients will be enrolled to receive a free smart phone/ digital phone application that will send the reminder messages to the clients about taking ARVs. The client will be able to send a feedback message to the system confirming that ARV was taken. Special follow up will be done to the clients who do respond to reminder messages. Clients will also be able to report to the independent point (INLS assigned) if the ARVs were not available in the facility, issues with confidentiality and other issues related to the quality of care.

- **Increase sales in FMCG** (fast moving consumer goods) retail sector and other non-traditional outlets

The current state of events often has the raids of economic police confiscating from non-pharmaceutical outlets, especially from kiosks and small retailers. Advocacy with the Ministry of Commerce, Economic police and other relevant ministries to authorize condoms sales in FMCG and non-traditional outlets is required. This activity aims at increasing access to condoms during off hours when pharmacies are usually closed. It will also likely grow the total universe of users by providing access to condoms to people who do not go to pharmacies or feel shy to request a condom from a formal outlet. Additional to working on the national level, advocacy on the same on provincial level is also required.

10. **Improving service access by children:** The noted limited access to services by children particularly for TB diagnosis, EID for HIV and paediatric ART has also been prioritized for improvement in this application, through stronger integration of HIV care and treatment into the RMNCH platform. Investments are being targeted to ensure improved access to optimum care and treatment for HIV exposed babies. Tracking mechanisms to actively identify and follow up HIV positive pregnant women and their newborns is also being scaled up using the community systems (ACS) approach with greater involvement of the civil society and community structures. Provider initiated testing and counselling (PITC) will be promoted for paediatric populations through under-5 service delivery points. In view of the relative under-diagnosis of TB in children, the roll out of new guidelines, trainings and the GeneXpert technology are a few interventions to be scaled up in this application.

11. **Geographic prioritization:** Geographic prioritisation is informed by the need to respond to the geographical variations to the HIV and TB epidemiology in the country and the need to invest for impact/ efficiently manage scarce resources. In this application, 18 municipalities from 9 provinces have been prioritized for the HIV prevention, care and treatment interventions. These municipalities have been identified by consensus amongst the TB, HIV and malaria programmes and ANASO for crosscutting service improvements linked to the HSS CN because they are characterized by higher than national average prevalence, high burden in terms of number of PLHIVs, increasing HIV prevalence over several years and relatively lower regional implementation performance on key HIV and TB indicators. These municipalities also have some of the few remaining operational NGOs and hence offer the opportunity to achieve improvements relatively quickly. Maintenance activities will continue in other regions but active scale up will be the approach of choice in the prioritized regions.

12. **Health Systems Strengthening and Human resource**: Investments in the health system are also being prioritized particularly around HMIS/M&E, operations research and Program management .The planned integration of both HIV and TB management information systems into the HIS is also a top priority. The place of operations research and the generation of survey data to inform program decisions are also being prioritized. Angola has submitted an HSS concept note whose investments in health work force at the community level will be leveraged by HIV and TB programs.

13. **Financial Sustainability:** The GOA is conscious of the need to establish a financial sustainability mechanism that will sustain the gains of the several investments in HIV and TB control. The narrative on the actions planned to address funding gaps these above details these plans and initiatives.

The Concept Note (CN) Funding Request

The Global Fund GAC has approved a revised ceiling allocation for HIV and TB for Angola of US**$** 40,519,982 for 24 months from first disbursement (expected in July 2016). The GF TRP has also approved the within allocation submission for these funds, subject to some clarifications and adjustments to be achieved during grant making. However, the TRP required a supplementary submission for the above allocation amounts in the February 2016 window. In this application, Angola is making a request of **US$ 46,773,689** above the approved ceiling allocation to fund implementation activities across the prioritized modules.

In response to the TRP comments and recommendations, and in the light of the requirement to resubmit an above allocation request, the HIV-TB Technical Working Group (TWG), with its partners, has re –evaluated the above allocation submission.

As requested the prevention programme for Sex Workers has been moved to within allocation. TWG also recognised the special vulnerability of young women out of school and has expanded and reprioritised the adolescents and youth module to include outreach programmes to young women out of school in the priority provinces. 50% of this part of the programme is now within allocation.

The objectives of the adjustments to the modules have also included an increased focus on alignment between the HSS CN community ACS and HIS modules to optimise the impact of the proposed interventions as well as ensuring that as many interventions as possible will be combined TB-HIV activities. In recognition of that objective, the TB-HIV activities in the CN have been brought together into a combined TB-HIV module.

Table 3, below, provides a summary of the changes to the above allocation request from the October 2015 submission to this current request, and the total above allocation request for this submission by module.

Table 3: Summary of changes to the ABOVE allocation request by module:

	Module	2016		2017		Total Above allocation
		Oct 2015	Current	Oct 2015	Current	
HIV	Prevention: General population	5,029,500	3,078,310	4,271,460	2,109,570	5,187,880
	Prevention: Adolescents, youth	2,239,200	6,638,400	2,239,200	6,638,400	13,276,800
	Prevention: MSM & TGs	1,256,385	1,256,385	1,108,235	1,108,235	2,364,620
	Prevention: Sex workers	194,400	-	194,400	-	-
	Prevention: Truck drivers	641,641	641,641	641,641	641,641	1,282,000
	Prevention: Miners	641,641	641,641	641,641	641,641	1,282,000
	Prevention: eMTCT	237,000	237,000	237,000	237,000	474,000
	Treatment, care and support	492,180	2,927,980	475,380	3,434,380	6,362,360
	HIS, M&E	1,715,385-	2,184,885	1,475,610	1,675,110	3,859,995
	Program Management	-	99,033	-	79,112	178,145
HIV- TB	TB/HIV co-infection	247,817	1,634,826	152,838	1,900,721	3,535,547

TB	TB care and prevention	573,038	907,086	777,409	1,196,057	2,103,143
	Control of TB-MR	950,545	950,545	211,957	211,957	1,162,502
	Program Management	-	90,000	-	90,000	180,000
	HIS , M&E	1,065,181	1,065,851	1,015,371	1,015,371	2,080,552
PR	UNDP	-	1,410,853	-	1,410,853	2,821,706
	MoH	-	319,082	-	302,678	621,760
	Totals	**17,228,179**	**24,082,236**	**17,713,187**	**22,691,453**	**46,773,689**

The changes to the **above allocation** request are as follows:
HIV modules:

a) Prevention in general population has decreased by US$ 4.1 million
b) Prevention, Adolescents and youth has increased by US$ 8.8 million
c) Prevention for sex Workers has been moved into within allocation.
d) Treatment care and support has increased by US$ 5.4 million.
e) HIS and M&E has increased by US$ 0.7 million
f) Programme management has increased by US$ 0.2 million.

HIV-TB module(s) has been combined and increased by US$ 3.1 million

TB Modules:

a) TB care and prevention has increased by US$ 0.7 million
b) Programme management has increased by US$ 0.2 million

PR costs have increased by $3.4 million

Proposed investment and description of how the request addresses the gaps and constraints

HIV Modules: Above allocation priority activities

Within the HIV modules, for the most part, the above allocation activities are discrete and additional to the within allocation activities. The descriptions here therefore relate to the above allocation activities.

I. Prevention programs for general population:

The reduction in above allocation for prevention in the general population is because of the transfer of activities linked to viral load testing out of the module and into care and treatment.

The following intervention areas remain the priority for above allocation activities:

a) *HIV Counselling and Testing*: Because of the economic crisis and the need to request ARV to sustain coverage, counselling and testing in the general population will be sustained at its current level only as a passive response. The number of counselling and testing sites will be maintained (1068- private and public) in all municipalities and emphasis will be put on improving quality of service delivery and prevention activities through improved supply chain management (HSS CN),

community based support (HSS CN). Counselling and testing services will put more focus key populations (MSM and TG, FSW), and other vulnerable populations (prisoners, truck drivers, miners, young girls and women, clients of sex workers), All HIV positive clients will also be screened for TB.

b) *BCC/Mass Media:* This intervention will produce and distribute BCC/IEC materials designed for specific target audiences, conduct awareness TV and radio programs about HIV/AIDS targeting general population and conducted with public figures from the worlds of politics, culture, sports and community leaders. The focus of the campaigns will be on protection, choice and gender equality. The radio programmes will be designed particularly to reach rural populations.

c) *Community awareness and mobilization*: To sensitise the general public on HIV/AIDS with a focus on men through events like football matches, and workplace programs with private companies where men can be targeted.

d) Promotion and distribution of condoms: This intervention will extend the promotion, distribution and education on the use of both female and male condoms for HIV prevention, placing condoms in strategic locations where the public can easily access them (particularly focusing on youth friendly access).

II. Prevention programs for adolescents and youth

The increase in the above allocation request for adolescents and youth comes from the addition of a programme for young women out of school, 20% of which will be carried out within allocation.

According to epidemiological data, adolescent girls and young women are among the most vulnerable populations with high infection rates, teenage pregnancies and abortions in Angola. Investment in this module will target adolescent girls in schools and colleges and young women out-of-school through a number of interventions including: Community sensitization through community agents and other partners and radio and TV campaigns; training of formal and peer educators through CSOs and with other partners (MINARS, MED, MINFAMU) to promote school and college based programmes for empowerment, sexual and reproductive rights to adolescent girls in high schools, colleges and universities; train activists through NGOs to develop mobile units promoting empowerment, sexual and reproductive rights to young women out of school in prioritised municipalities and linked to clinics providing youth friendly services and access to modern contraception and treatment of STI*;* conduct awareness campaigns and sensitization aimed at women of childbearing age for counseling and testing; conducting biannual meetings at national level for closer integration of national prevention of unwanted pregnancies in girls and women; promotion and distribution of condoms. The within allocation activities have been changed to outreach services for young women out of school and this is further expanded with the above allocation request

III. Prevention programs for Key Populations (MSM and TG, FSW, Truck drivers and miners)

The above allocation requests for MSM and Transgender and Truck drivers and miners all remain unchanged. The module for sex workers is now entirely within allocation.

According to the population size estimation modelled on regional data, the number of MSM and TG was estimated to be 61,963;, Truck drivers 122,000 and miners 64,500. A recent sero-prevalence study (2015) among Key Population revealed HIV prevalence rate of 8.2% amongst MSM. PSI has been implementing prevention programs among MSM, FSW and

Truck drivers in five provinces in Angola between 2011-2014. PEFFAR/ Linkages project began in 2015 to implement prevention programs targeting KPs mainly in five provinces in Angola, but has now moved its focus to Luanda During the CN implementation period PEPFAR/Linkages project plans to target 3,500 MSMs & TGs in 2016 and 2017 in 2016 and 2017.

Targets in this above allocation request are: For MSM, targets are to reach 11% (7,000) in 2016 and a further 12% (totalling 14,650) in 2017; For truck drivers, targets are 20,000 in 2016 and 2017 (total 15%), while for miners targets are 11,200 in 2016 and 2017 (total 15.9%). PWIDs are not targeted in this CN because the national consensus is that they do not constitute a sizable population and may be difficult to access. PEPFAR/Linkages and SADAC are currently conducting a size estimate study among KPs (MSMs, TG, FSWP, PWID) to obtain more reliable estimations of the numbers of KPs. The within allocation request covers behavioural mapping studies on miners and truck drivers. When these data become available, INLS will use these to revise the targets set in this CN for improved programming.

Interventions among key populations will focus on advocacy and stigma reduction, BCC interventions and harm reduction, HCT, STI Management and TB screening, Condom promotion and provision of water based lubricants (for MSM), training health workers to provide KP friendly services, strengthening referral systems to access ART/DOTS services, support to CSOs and KP association to implement mobile outreach clinics for miners and truck drivers, peer education, testing and counselling among KPs.

III. PMTCT

The above allocation request for PMTCT remains unchanged. The bulk of the total request is within allocation for the provision of ARV.

Angola has adopted the PMTCT Option B+ strategy to eliminate HIV transmission from mother to child (eMTCT) in tandem with global targets. Challenges identified to achieve eMTCT include low institutional delivery coverage (40% MICS 2011), and low ANC attendance rate of 70% at least once among pregnant women, HIV stigma and discrimination, and lack of male involvement in PMTCT strategy. Because of the financial crisis the primary (within allocation) request is to sustain treatment coverage so only a modest scale up of treatment is envisaged in line with the sustained current level of testing. The objective of the remainder of the within allocation and the above allocation is to focus on prevention and attempt to improve knowledge amongst women of child bearing age around prevention of HIV and STI, family planning and the impact of nutrition and alcohol on low birth weight, stunting and child mortality. This will be achieved through radio and TV campaigns

III. Treatment, Care and support

The increase in the above allocation request for treatment care and support is the transfer of viral load and CD4 machines plus cartridges and test kits from the prevention module. At the time of the previous application Roche had offered to provide a viral load machine and training in Benguela. Since then they have insisted the machine must be in Luanda, so this

application has added the cost of the machine support and training for the proposed additional testing service in Benguela.

The National ART Guidelines have been revised in line with the WHO 2013 ART guidelines. The focus of the above allocation interventions is to improve the quality of treatment and care among adults and children receiving ART and emphasis is on comprehensive clinical and laboratory monitoring of adults on treatment through routine CD4 cell count and viral load testing and for early infant diagnosis (EID / DPI). The expansion of EID, training and supervision is to reference centres nationally, but the viral load laboratory service will be in Benguela and will provide referral services to neighbouring provinces.

IV. HMIS and Monitoring & Evaluation

The increase in the HIS above allocation request is the result of the re evaluation of the activities which were considered to be under resourced to deliver the required coverage and interventions.

INLS has procured an HIS system in 2013 and finds that it does not provide the data required for its purposes. In order to overcome this INLS is introducing key instruments for data collection for loading into the system to provide the first level of strategic information. INLS and PNCT have gained valuable experience through their data collection and recognition of the shortcomings of their systems. The Ministry of Health, financed through the approved HSS concept note, is planning to strengthen an integrated and robust HIS system at national and sub-national levels, and INLS will participate in this process in line with the principle of the “Three Ones”.

Whereas both HIV and TB programmes have an urgent need to develop functional systems, they recognise the need to engage with the broader long term development of national systems, and will work alongside the development of the national HIS to develop modules that can be incorporated in the national system when appropriate.

This application will strengthen capacity of service (PMTCT/HCT/ART) sites, municipalities, provinces and national level to fully integrate into the national HIS system and support the revision of the HIV M&E system to cater for both TB and HIV program indicators. Additionally, this application will support INLS to conduct key studies required to measure program outcomes and impact; and inform future programming.

V. Programme Management

The increase in programme management in the above allocation request is a marginal cost increase for the additional resources required to service the above allocation grant.

This intervention plans to continue supporting the PR in grant implementation to monitor the SR activities, and the INLS in its coordination role of the HIV/AIDS multi-sectoral response in Angola. INLS functions as a decentralized body to undertake its coordination role at provincial and municipal levels. The application will support the training of key program staff for the programme, particularly in financial management and monitoring and evaluation.

TB/HIV Module: Above allocation priority activities

Within the TB/HIV integrated service collaboration module, for the most part, the above allocation activities are discrete and additional to the within allocation activities. The descriptions here therefore relate to the above allocation activities.

The increase in the above allocation request for the HIV-TB integrated service module arises from the costs of tests for TB and for the Isoniazid prophylaxis required for TB negative PLHIV, both of which were omitted from the previous application because they were seen as government, not TB programme, expenses.

The above allocation interventions aim to improve the quality of care of TB/HIV services by strengthening collaboration and linkages between HIV and TB programs. Extensive training and supervision programme to develop and / or educate and integrate the HIV and TB services at facilities will attain this. This will result in i) integrating TB screening and diagnosis in eMTCT/ ART/HCT services; ii) increasing the TB case detection rates among PLHIV/PMTCT and HCT clients; iii) decreasing the burden of tuberculosis among PLHIV; and iv) decreasing the burden of HIV among tuberculosis patients. HIV positive individuals accessing HIV/AIDS care services at HCT, PMTCT and ART sites will be screened for TB disease and those testing positive will be provided with TB services for treatment as a part of the integrated one-stop service. HIV positive individuals who do not test positive for TB after being screened will be offered Isoniazid Preventive Therapy (IPT) according to national guidelines.

This application has set ambitious targets for management of TB/HIV co-infection:

For TB screening amongst known PLHIV, the above allocation funding will provide 50% of the increase in testing coverage provided by the grant. 71,339 PLHIV in 2016 and 142,692 in 2017, reaching 75% of PLHIV eligible for screening who will be in HIV care. For IPT, this application will reach 9,773 in 2016 and 19,549 in 2017, reaching 14% of all PLHIV and 100% of all eligible for IPT in HIV care (WHO regional estimate).

For HIV testing amongst TB patients, this application plans to target 8,151 (100% of TB cases detected among PLHIV screened) in 2016 and 8,230 (100%) in 2017 of all TB/ HIV co-infected patients and put them on both ART and DOTS. These ambitious targets set in this application demonstrate the commitment of government of Angola towards the Global STOP TB plan.

TB Modules: Above allocation priority activities.

Within the TB modules the above allocation activities are almost universally extensions of within allocation activities, expanding the service delivery base. The increase in activity is measured proportionally.

I. TB care and prevention

The increase in the above allocation request arises from the addition of the payment of stipends to the ACS trained in the DOTS C community based care expansion, which had been omitted in the previous application**.** It also includes the provision and training for an additional 4 GeneXpert machines to bring the total up to 20 (1 per province and 3 in Luanda).

The PNCT focuses on interventions to ensure continuity of interventions initiated with the Round 9-GF: The priority interventions selected under the module are broad based training, monitoring and supervision of nurses in facilities to improve; (a) case detection, diagnosis and treatment (30% increase); plus (b) inclusion of prisoners as a vulnerable population (15% increase) and (c) the expansion of community TB care (100% increase). The above allocation activities will also provide national guidelines for TB laboratories and provide additional GeneXpert consumables.

The implementation approach will be as follows:

a) *Case detection and Diagnosis*: The approach to be adopted in general terms will involve a mix of strategies. Proven service delivery mechanisms will be scaled up and new focus towards populations in areas of high burden and particularly in under-performing municipalities. The following case finding measures to increase case detection will be implemented:

   i) Training of health service providers in TB care and prevention interventions. Health professionals from 19 additional health facilities will be trained annually with supervision
   ii) Development of national guidelines to strengthen laboratory service and provide a uniform operating framework.
   iii) The within allocation request includes 4 GeneXpert machines. The WB will provide a further 10. CDC and CUAMM have provided 2 machines, and the above allocation request is for a further 4 machines (plus training and consumables) to provide full national coverage.
   iv)

b) *Involvement of Key affected Populations*: This intervention will focus on prisoners, mining communities and people living with HIV. Specifically, training of prison staff for active case finding and systematic screening, Currently there are 24 penitentiary centres with approximately 24,000 prisoners. The above allocation request will cover an additional 2 prisons for training of health workers in the management of TB and TB screening, HIV, MDR-TB with monitoring of the patients in treatment and control of the contacts.

c) *Community TB care*: This intervention will involve an active process of empowering communities to refer patients suspected of having presumptive TB; promote social mobilization for TB interventions using ACS (refer to HSS concept note); and implementation of TB social and behaviour change communication strategy (BCC). Also training of community health workers (ACS) to monitor the completion of TB treatment and the provision of monthly incentives for active tracing of defaulters will also be funded by leveraging resources of ACS in the HSS concept note. The above allocation request covers the expansion of the GF Round (DOTS C programme into an additional 5 municipalities in 5 priority provinces where both the defaulter rates are the highest and the treatment success rates the lowest.

II. MDR- TB (Diagnosis and treatment)

There is no change in the MDR above allocation request

This is a flagship module for the CN as it will provide the foundation for the National MDR-TB program. WHO is supporting PNCT in the development of an MDR strategy. This application is an agreed minimum baseline for staff and distribution of services, which will be adjusted once the strategy has been completed. The targets are therefore restricted to implementation of the minimum and so achieving 100% is expected. This above allocation application plans to provide diagnosis and treatment of 62% of the total of 8,500 tested and

represents 31% of the total anticipated need in 2017. It also plans to train 280 out of the total of 850 staff required in the MDR TB treatment network in the 18 provinces. This request is supported by the additional request in Treatment and care module for 4 more GeneXpert machines.

The following interventions were selected for this module in priority order (a) MDR TB case detection and diagnosis (b) MDR TB treatment

a) *MDR-TB detection & diagnosis*: This above allocation request includes 4 GeneXpert machines in addition to the existing and within allocation request. The national MDR-TB program will be jumpstarted with the procurement and installation of GeneXpert molecular technology platforms in 18 laboratory sites. There is currently 1 functional laboratory with GeneXpert technology located in Cubal - Benguela and 3 laboratories performing culture with liquid assays, located in the reference laboratory and 2 Hospitals Sanatoriums (Luanda and Huambo). The PNCT will provide GeneXpert to 4 laboratories with funding from Global Fund Round 9 transferred into this allocation and the Government will provide to 10 GeneXpert platforms to 10 laboratories, purchased by GOA through World Bank. With the 4 additional machines the network will be national with a reference centre in each province and additional capacity in Luanda and Benguela. This network will improve access to diagnostic services of MDR-TB in the country. Training, supervision and mentorship of health care workers on the use of new diagnostic technologies as well as procurement of consumables (e.g GeneXpert cartridges) and supplies will be supported from the application amount.
b) *MDR-TB treatment:* All detected MDR TB patients will be enrolled for treatment. For the management of patients diagnosed with MDR-TB, the country currently has three reference centers (Sanatorium Hospital of Luanda, Cubal Hospital (Benguela) and Huambo (Hospital). The plan is to ensure the presence of a network of 43 trained nurses and doctors in each province for diagnosis, follow-up and monitoring of patients for MDR-TB in accordance with WHO guidelines for DOTS Plus. The above allocation request will provide 62% of this expansion. Regarding acquisition of drugs, since 2011 Government purchased on an annual basis 1st and 2nd line drugs based on the expected number of cases to be detected. In 2013 World Bank provided a contribution to purchase 2nd line drugs. Currently 1st line and 2nd drugs are available and programme needs are covered for up to 2018.

III. HMIS and M&E

There is no increase in the above allocation request for HMIS and M&E, which amounts to 68% of the total grant request for the module.

The Ministry of Health, financed through the approved HSS concept note, is planning to strengthen an integrated and robust HIS system at national and sub-national levels, and PNCT will participate in this process in line with the principle of the “Three Ones”.

Whereas both HIV and TB programmes have an urgent need to develop functional systems, they recognise the need to engage with the broader long term development of national systems, and will work alongside the development of the national HIS to develop modules that can be incorporated in the national system when appropriate.

The following interventions have been selected for support through this application – (a) Routine Reporting (b) Analysis review and transparency (c) Improving Program capacity to manage TB program data.

a) *Routine reporting:* This intervention will involve support for the revision of reporting tools to ensure data integrity, develop and dissemination of data tools including printing and orientation; collection, aggregation and analyses of program data at the municipal and facility level; strengthening of electronic data management skills at municipal level.

b) *Analysis review and transparency:* In this intervention, allocated funds will strengthen regular and joint supervision activities; Support the capture of TB data in Municipal Health Information System and; support the review of the TB M&E system to cater for both TB and HIV program indicators.

c) *Data management capacity:* As part of the capacity building of the PCNT, funding for this module will support capacity building on long and short team courses for Monitoring and Evaluation teams in the PCNT; Procure TA for developing and costing the TB Monitoring and Evaluation plan and build capacity at the municipality level in data management and analysis.

IV. Programme Management

The above allocation request for programme management arises from a 15% increase for additional support for the increased grant amount from the above allocation request.

Selected interventions under this module include (a) Promote policy and planning Coordination (b) Improve Grant management

a) Promote policy and planning Coordination: This application will help national program (PCNT) strengthen its capacity to implement program. This application will support coordination meeting as at national and provincial level, printing and dissemination of TB guidelines, training of key program staff, support advocacy, support to municipalities to incorporate TB activities in the municipal plans, and activities for World Stop TB day. This module will contribute to the mid-term evaluation of the PEN-TB 2013-2017.

b) Improve grant management: The majority of the management module cost is anticipated for support through Technical assistance for national and provincial programmes. .

PR Costs: Above allocation amounts

The PRs for the CN are UNDP (HIV) and the Ministry of Health (TB and HIV TB)

The increase in PR costs for the above allocation request arises from the addition of PR costs for above allocation, which were not allowed for in the previous application.

UNDP charges a general management services (GMS) cost of 7% on within and above allocation amounts, plus an additional charge for direct costs. These have been calculated by UNDP and form part of the application. UNDP has only charged marginal additional direct costs for the above allocation request.

Ministry of Health (MoH): Detailed costs for the PR function for the Ministry of Health will be determined during grant making. The MoH is joint PR for the Malaria, HSS and TB CN, and the Project Management Unit (PMU) will manage the grants. The TB component will be a portion of the total. The allocation within this request is

therefore only indicative and amounts to 7% of the chargeable grant total. It is likely the allocation will be proportional to the funding amount across within and above allocation.

The MoH carries out the PR function for the TB-HIV collaboration module because the majority of the costs for the TB-HIV module fall to TB (tests and IPT).

3.3 Modular Template

Complete the **modular template (Table3)**. Note that the template allows access to modules that are specifically relevant to TB and HIV components, in addition to modules that are crosscutting for both diseases.

To accompany the modular template, for both the allocation amount and the request above this amount, explain:

a. The rationale for the selection and prioritization of modules and interventions for TB and HIV, including those that are crosscutting for both diseases.

b. The expected impact and outcomes of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

3-4 PAGES SUGGESTED

A. The rationale for the selection and prioritization of modules and interventions:

In the following text, each item has a reference number or numbers (in brackets) and a priority ranking preceding the text. These numbers refer to the lines in the excel table schedule provided as supporting documents with the individual activity costs.

The above allocation has been built up around the following factors:

- For HIV, the ultimate goal of 90/90/90 by 2020 as per Angola´s Strategic Plan. For TB, detection of 85% of BK+ and treatment success rate of 85% on simple TB are the strategic goals
- Abrupt changes of the economic environment that make some prior governmental goals impossible to achieve without external support
- Synergies that can be achieved with the most important activities of the in-allocation and HSS CN activities
- Cost-efficiency, feasibility and expected impact on the drivers of both infections

The national HIV/TB technical working group has examined the needs to achieve strategic goals and cover for possible gaps in a systematic manner. As a result of the analysis, above allocation is requested for the modules described. The overarching rationale for the selection for prioritising the interventions is:

HIV: High level rationale:

Within the context of the financial crisis in Angola, and the inability to expand coverage of essential front line services, the highest priority for the resources requested for the HIV above allocation grant are focused in three modules, focusing on prevention and quality, without which Angola cannot advance in the national response: prevention of HIV infection in adolescents girls and young women, increasing access to viral load for people on ARV treatment.

These three blocks are essential for the implementation of the National Strategic Plan and to continue progress towards achieving the goals of the UNAIDS 90/90/90.

The module for adolescents and young girls focuses on activities for young people; those who are in school, but especially for those that are not in the school system. Enrolment of girls in school is low (17%) and the high proportion out of school has little education, are amongst the poorest communities. The large numbers of girls who are out of school are the ones most likely to be in a situation of abject poverty, are more vulnerable to unequal sex and in sexual exchanges with no possibility of negotiating the use of the preservative. Studies of behaviour and practices carried out in Angola have shown that lower knowledge about HIV and its transmission are associated with low education.

Increased access to viral load is essential to monitoring, responding to and hence the achievement of the goal of the UNAIDS target of 90% suppression of viral load; thus allowing the country to monitor the PLVIH on ARV treatment, with direct gains in quality of care and reducing HIV transmission.

HIV and TB: High level rationale:

In relation to Monitoring and Evaluation, one of the biggest weaknesses of the country is the low capacity of data collection and analysis on the Tb and HIV epidemic. The proposals described in this CN aim to build a network of quality of data collection, with case reports of HIV/AIDS in adults and children, pregnant women with HIV and individual prescribing ARVs for HIV and the management of cases in treatment, abandoned treatment, remaining symptomatic, bacteriological resistance and prescribing patterns on 1st and second line treatment. The proposal includes training in epidemiological surveillance, consulting to system deployment and improved data analysis, resulting in a solid basis for planning prevention and treatment, knowledge of risks and vulnerable populations, managing ARV and TB drugs from procurement to the delivery to the patient, and to measure performance against international and national indicators. All these activities are expectations of the Health Information System in the country, and the activities must link directly to the developments provided for in the HSS Conceptual Note.

TB HIV coinfection is a prime indicator of mortality and both national programmes recognise the essential nature of a coordinated and integrated one-stop approach to the management of the interface of the diseases.

TB: High level rationale.

Within the context of the financial crisis in Angola, and the inadequacy of service provision in many areas of the country inhibit the provision of quality essential front line services, the highest priority for the resources requested for the TB above allocation grant are focused in 4 areas, focusing on prevention and quality, without which Angola cannot advance in the national response: Vulnerable populations (prisoners), community based services, health information systems and diagnostics (GeneXpert).

Prisoners are a neglected vulnerable population. As in other congregate settings they are prone to TB infection, and the impact of the rotation of people through prisons has a knock on effect of TB infection at a population level. The impact of the prisons on the wider community is out of proportion to the numbers incarcerated.

High defaulter levels, low adherence and poor success rates can be addressed through a strong community based programme providing DOTS, contact tracing and treatment follow for defaulters. This is seen as an essential development of the service to deliver long term improvements in TB control.

GeneXpert as a technology offers significant potential for dealing with diagnostics issues, particularly amongst key and vulnerable populations. The key issues are the early detection of rifampicin resistance and detection of TB in populations likely to return sputum negative results, which together will have a large impact on sound diagnosis and improved treatment results.

PRIORITIES FOR HIV MODULES

1. **Key populations - MSM, truck drivers and miners (3 separate modules)**

Due to the utmost importance and as per recommendation of the TRP, the entire module for sex workers has been moved into within allocation. Therefore, the sex worker activities no longer appear in the above allocation.

As for further key population groups, numerous activities were included in the Priority 1 group, seen the absence of any such activities in the past.

1a. MSM

(29) Priority 1: Draft, validate and bring into force the First Strategic Plan for HIV/AIDS for key populations, as they have not explicitly included into the original National Strategic Plan. The National Plan for key populations will be a significant step forward to address human rights issues and the epidemiological driving factors.

(31) Priority 1: As the economic situation does not allow adequate measures to be added to the reduced MoH budget, the outreach for the difficult-to-reach MSM group is crucial in the above allocation. The MSM module will be implementing counseling and testing mobile trucks and existing methodology from project LINKAGES in close cooperation with PEPFAR and the implementing party MSH/FHI as well as local civil society organizations**.**

(30) Priority 1: -Training of health providers of key facilities to improve access for MSM and to eliminate stigma and discrimination based on existing methodology of PEPFAR.

(33) Priority 2: Through trained peer counselors and local groups, support adherence of MSM on ARV treatment. The data generated will be also useful, as little is known about adherence behavior of any part of population.

(32) Priority 2: Purchase lubricant to be provided to the MSM to complement above activities to reduce the risk of transmission.

(34) Priority 2: Create and distribute IEC content & form appropriate for MSM. Most IEC content up to now was based on the principle of heterosexuality and medical focus, so that creating adequate IEC content to accompany the above messages would be useful.

1b. Truck drivers and miners (separate modules, similar activities)

The module for miners and truck drivers includes three above-allocation activities. There have never been activities for these two groups implemented by the MoH and due to budget constraints; no activities could be included in the in-allocation. However, in the above allocation, activities can be undertaken in a cost-efficient and concerted manner between the two groups as well as between TB and HIV.

The miners (both in the formal and the much larger informal sector) are located in the distant provinces of Lunda Sul, Lunda Norte and Malange. Main long distance truck driver routes are along the coast, cutting Angola from East to West and on the Kunene-Bie-Lunda Norte axis**.**

For these 2 modules the priorities are as follows:

(49,57) Priority 1: Implementation of mobile testing and counseling trucks, training and outreach by peer education at identified hotspots. There was a very good prior experience with the several existing testing and counseling trucks in the outreach for general population.

(48,56) Priority 2: Train health providers in 45 key location facilities (each group) on both health related issues and approaches to stigma and discrimination

(50,58) Priority 2: Supplementary targeted IEC (several channels - direct and indirect) to support the two prior measures.

Two experienced organizations, MSH and PSI, have been working on defining an approach to be undertaken for miners and truck drivers and will be included in the implementation.

2. Prevention in general population

This module involves a range of different activities: counseling and testing, legal environment and multi sectorial coordination**.**

(13) Priority 1: Due to the significantly reduced access to hard currency and exponential fall of the local currency in the past month, the MoH may not be able to acquire adequate amounts of HIV tests, notwithstanding the commitment to the 90/90/90. The technical working group has therefore prioritized the purchase of HIV diagnostic tests in the above allocation. They will serve to achieve goals in several modules: test pregnant women, young woman adolescents, key population, and general population.

(5) Priority 2: Work together with Ministry of Social Affairs and Ministry of Family on diminishing and eliminating stigma and discrimination of HIV+ impacted children, in particular orphans.

(6) Priority 2: Train trainers for all provinces on the integrated approach counseling, testing, stigma, discrimination, TB, STI and SSR to be implemented and municipal and commune level. The approach in the past on primary level has been focused on the HIV medical aspect. It would be very useful to transfer the integrated overview to the lowest implementation level.

(8) Priority 3: Organize a multi sectorial workshop with strong participation from provincial and municipal level to reinforce the access and functioning of social services.

(14) Priority 3: Purchase male and female condoms. For the condoms, the MoH may be in budget difficulties to purchase for the upcoming budget periods, therefore the consideration for condom purchase (about 24,0000,000 condoms each year) was included in the above allocation that would serve both the key populations and promotion among general population.

(4) Priority 3: Campaign on radio and TV is proposed as a cost efficient supplementary component. The TV will issue promoted messages free of charge. Successful content already exists from past campaigns.

(6) Priority 4: Workplace trainings and interventions together with the private sector. While the affluent oil industry has invested in the HIV at workplace policies, some industries such as local construction companies might been less diligent and therefore, supplementary funding can be used to leverage interventions in this sector, both for STIs and HIV.

3. Prevention: Adolescents and Youth

With fertility rate of 6 children/woman, 52% percent of Angolan population is under 15 years of age. Sexual activity and teenage pregnancies are high, while the use of family planning methods stays among the lowest in Africa. The rate of infrequent transactional sex encounters is not known but estimated to be significant. The girls with lower education levels are more vulnerable to sexual pressure by their peers, relatives or older men.

The Angolan HIV technical working group considers the top priority is to concentrate on girls and young women. The technical working group has prioritized the entire area based on the fact that prevention is the most cost-effective measure in the fight against HIV and AIDS.

(23) Priority 1: A program for youth out of school is being proposed as first priority, including promotion of voluntary testing, condom use and education of young women on sexual and reproductive rights. National and international NGOs, Ministry of Social Affairs as well as Ministry for Family will be included in these activities.

(23) Priority 1: Same prevention outputs (voluntary testing, condom use, life skills) through a programme in the schools - high numbers can be achieved with a different methodology.

(22) Priority 2: As a cost-efficient supplementary component to the above measures, IEC campaign on the radio and TV is suggested. The TV will issue promoted messages free of charg**e.**

(25) Priority 2: Reaching population of young women at universities would be an important task, as there are indications that the prevalence between urban educated women is high. as per Rod´s mail this morning.

4. PMTCT

The in-allocation focuses on PMTCT as the rate of mother-to-child transmission is still inadmissibly high. Currently 45% of all pregnant women are getting tested, yet a scale up to the target of 90% is needed.

The above allocation is planned to support the following measures

(64) Priority 1: Targeted campaign in all health posts intended for sensitisation of women in reproductive age and women coming for antenatal visits in particular

(65) Priority 2: Campaign on radio and TV is proposed as a cost-efficient supplementary component. The TV will issue promoted messages free of charge and Successful content already exists from past campaigns

For further activities in the framework of PMTCT, see also the M&E module.

5. Treatment care and support

The main 2 lines of the above allocation request under this module go into access to viral load access testing in line with the 90/90/90 commitment of the Angolan MoH and EID viral testing for children.

(75,76,79) Priority 1: Establishment of a viral load laboratory with related activities. While a second viral laboratory will be established in Luanda in 2016 with governmental and private sector monies, with the above allocation request, for the first time, a viral load lab would be launched outside of Luanda, in Benguela, with collection and analysis of samples from the Southern provinces, reaching 5-8 provinces. With this measure, Angola will be reaching the provincial and non-urban populations. A detailed and continuous (on the job) training will be offered for all jobs around the viral load operations as well as regular supervisions and quality assurance.

(72,80) Priority 1: Create a testing site for the introduction of EID viral load testing. Conduct training in two provinces on EID viral load testing

(81) Priority 2: Supplementary Supervision at sites where EID was implemented

(10,11,12) Priority 2: Organize central supervisions to Benguela to oversee the implementation of the viral load testing referral. Organize provincial supervision to the local level for the viral testing organization, referral and follow-up.

(9) Priority 2: Organize integrated annual supervision of service improvements (line 7) in a cascade from national to provincial and municipalities.

(73,74) Priority 2: Improve treatment of children through 2 activities - creating and implementing a protocol to accompany HIV+; train health workers at units that treat HIV+ children

(77,78) Priority 3: The government may not have resources to guarantee seamless functioning of CD 4+ in the period to come, so that if resources were available they would be used for contingency planning for CD 4+ maintenance and cartridges.

6. M&E capacity of national HIV effort

The reinforcement of M&E capacity is a new module that due to budget limits was not included in the in-allocation.

The quality of HIV effort in the country is directly dependent on the M&E capacity and M&E organization at INLS and all levels underneath. In comparison to other health departments of the MoH, INLS has better ability to collect and analyze data, incl. the implementation of the Spectrum-based software. However, important data, e.g. on adherence and patients per type of treatment are missing. Reporting from primary structures is mostly not timely and often not reliable. Reinforced cascade of supervision combined with on the job and reporting training, creation of more robust, reliable procedures for data collection and processing is therefore a priority the above allocation.

(102,103,104) Priority 1: Notification form on seropositive pregnant and parturient mothers and their children will be introduced on the national territory outside of Luanda. The component includes three activities of improving the form, training, supervision and follow-up. This output will improve the reporting in general and avoid the duplicities of reporting seropositive second-time pregnant or mothers that are reported as pregnant & in

the adult category. Further, implementation of singular notification for HIV/AIDS in adults and children: as part of the National Health Information System This strategy will give to INLS data who will make possible to know the country epidemiology of HIV. Implement the National Form to ARV prescription, that will give to INLS the real number of ARV patients in ART and their treatment schemes.

(98,99,100) Priority 1: Provide training to HIV counselors and data clerks improving their computer and data processing skills, broaden access to data processing software and patient management system; creation, promotion and dissemination of a manual for Data Entry and processing, in order to harmonize the procedures nationally.

(100) Priority 1: Provide at least quarterly supervision/ on the job training visit to each VCT and treatment site. With the reduced MoH budget this frequency, required for ensuring standard of care, cannot be sustained.

(96) Priority 2: Improve coordination in order to harmonize data collection and oversee that corrective actions are implemented.

(97) Priority 3: Undertake a coordinated effort within MoH from highest to peripheral level to reduce unwanted pregnancies in seropositive women.

PRIORITIES FOR COINFECTION TB/HIV

The priorities of the co-infection grant components are based on a separate National Plan for co-infection HIV/TB.

The priorities of this plan are as follows:

(38) Priority 1: Study of HIV/TB in miners and prisoners. Such study is crucial, as i) there is no existing data ii). Apart from the formally employed miners, the health system has not taken a systemic approach to these two groups prior to this date.

(37) Priority 1: Joint supervision and on the job training to facilities that implement/plan to implement coinfection counseling, testing and/or treatment

Priority 1: Joint TB/HIV meetings on common approach and data analysis.

(34) Priority 1: Training at laboratories at provincial level - prison health facilities and church based health facilities on co-infection testing.

(33) Priority 2: Training at central and provincial public laboratories on co-infection implementation.

PRIORITIES UNDER TB COMPONENT

Angola´s large sparsely inhabited territories and long distances to health facilities limit the practical implementation of the TB programme, which inhibits case detection and treatment. Also, the TB programme has relatively low resources compared to HIV, in spite of the high

costs of a sustainable MDR- testing and treatment component. The commitment of more resources based on higher estimates of prevalence (WHO 2014 vs. 2015) could not been carried out due to abrupt economic changes. Within this context the following allocation priorities were derived:

1. Treatment care and support (includes standard of care, M&E, DOTs-C, laboratory)

1a. Capacity development

The health facilities and staff provide a variable standard of care, so that a priority of the above allocation is to reach a robust, stable, responsible standard of care through practically oriented training

(7,11) Priority 2: Training for nurses, statisticians and logisticians in all 18 provinces on health information system, logistics and data analysis

(10,20) Priority 2: Supervision visits from central and provincial levels to monitor quality of case management

1b. M&E

The reliability and existence of data is of significant concern. As a priority, support for data analysis for both general populations and key populations (prisoners) is requested.

(9,12) Priority 1: Yearly M&E meeting on data analysis in which several delegates from each province can participate. Such enlarged meetings are for economic reasons currently not possible, however they would be important to have the buy-in and understanding of provincial level of TB and coinfection significance.

(5) Priority 2: Reinforce training, supervision and monitoring at central and provincial level. Redefine and/or fine tune data collection and reporting tools

1c. DOTS C

The DOTS C has only started in Angola under previous GFATM Round. The communitarian approach is very important in a country with large distances, low knowledge on health and low health seeking behavior. The in-allocation requests to continue the DOTS C pilot and the above allocation requests to extend it into 5 more provinces using synergies with the HSS component

(14) Priority 1: Train community health agents on social mobilization in TB care.

(16) Priority 1: Reinforce the supervision of the DOTS C component. As the DOTS C is regionally scattered and only just started, the proposal of the above-allocation is to reinforce the supervision.

(15) Priority 2: Create exchange and cooperation among DOTS C organizations (churches, NGOs) through regional meetings.

(17) Priority 3: Create more IEC materials to cover the scale up of DOTS C.

1d. Laboratory component (smear and LED)

Angola has yet to achieve sufficient laboratory coverage and it is one of the main goals of TB National Plan. Because of this relevance, most laboratory reinforcement was included in the within allocation The technical group has identified the following activity for above allocation.

(27) Priority 1: The expansion of the GeneXpert machines is considered a high priority for TB and MDR TB (rifampicin resistance) detection, especially amongst vulnerable populations with TB disease who often have sputum negative results. An additional 4 GeneXpert machines and consumables are requested to provide full national coverage (18 provincial reference centres).

(26) Priority 3: Due to budget disruptions, the government may not have the entire amount to provide all the registers, norms distribution and maintenance of equipment. The budget requested in the above allocation would serve as contingency for these disruptions.

2. Key population - prisoners

The most important activities were put into the in-allocation. However, seen there was no systemic approach prior to the current GFATM TB grant, the technical working group concluded that key population approach should be further strengthened

(19) Priority 1: Strengthening data collection, meeting and awareness building of all stakeholders of the component (prison authorities, Ministry of Interior, churches)

(21) Priority 1: Annual multi sectorial meeting and joint data analysis. The awareness about the possible magnitude of TB (and HIV) at prisons among stakeholders within and outside of MoH may not be strong. Commitment needs to be created based on gathered evidence.

(20) Priority 2: The line of activity intends to slightly increase within allocation budget to cover sufficiently monitoring of penitentiary institutions

A study of HIV-TB amongst prisoners is included under the co-infection component.

3. MDR TB

Financing for MDR will be provided by the within allocation, and the GOA commitment to provide 10 GeneXpert machines (WB loan) will scale up the one existing church-owned GeneXpert in the country. However, as MDR treatments only started in 2013, it is important to reinforce supervision and provide refresher training.

(41,42,43,44,46) Priority 2: Provide additional classroom and on-the-job training and supervision on the MDR-component for provincial laboratories. Thematic Areas: laboratory, treatment and follow-up on cases, reporting**.**

(47) Priority 2: Implement MDR laboratory quality assurance.

(45) Priority 3: Due to the restricted budget, not enough registries and norms for distribution may be available for the new laboratories. This budget line would therefore function as contingency.

4. Health Information Systems (M&E and studies)

Like for HIV, M&E strengthening for the TB component is considered crucial.

(50,51) Priority 1: The main M&E strengthening tasks identified for the TB component above-allocation are: revision of TB data reporting tools. Training (classroom and on the job) on data collection and processing at municipal level. Data entry and analysis on provincial and central levels (2 activity lines altogether)

(54) Priority 1: Conduct a MDR/TB study. The methodology and work plan for the study have been elaborated with support from CDC, yet no funding for the follow up exists. This is an important undertaking because the MDR-resistance could be significantly above the WHO estimate of 1.7% in the new cases[32] While there will the expected growth of cases of MDR, a study on MDR prevalence has been planned since years but has not been able to be conducted within the framework of MoH reduced budget

(53) Priority 2: For deepened understanding of national staff on M&E and lesser dependence on external technical assistance, participation in external M&E courses is suggested

B. The expected impact and outcomes of the interventions being proposed

OVERVIEW OF PRIORITIZED MODULES

Since above allocation funding for programme management and the PR is a marginal cost scale up of within allocation activities for the same outcomes, they are not included here.

HIV Modules

In the HIV modules the above allocation activities are discrete and additional to within allocation activities and so the impacts described can be attributed directly to above allocations funding.

The module for sex workers is now within allocation and so is not included here.

Module: HIV Prevention Programs for the General Population:

2016		2017		Above allocation Total
Within Allocation	Above Allocation	Within Allocation	Above Allocation	

[32]https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=AO&LAN=EN&outtype=html

1,138,410	**3,078,310**	1,050,000	**2,109,570**	**5,187,880**

Target population & Geographical scope

General population nationally, especially women.

Prioritized above allocation interventions:

- Edit, produce and distribute education and communication materials for IEC / BCC activities adapted to targeted audiences.
- Carry out awareness campaigns for behavior change for general population.
- Work with civil society and other partners (ONASO, churches, MINARS , MINFAMU) on specific prevention measures for women.
- Work in partnership with civil society (MINARS and MINFAMU) to develop and implement a joint plan for mitigation of stigma and discrimination against KPs and PLWHA, and for the protection of rights of orphans and vulnerable children.
- Work with soccer teams and other events to target men.
- Conduct workplace programs including education and awareness interventions in companies in partnership with private sector
- Procure and distribute male and female condoms, and increase access to condoms by placing them in strategic locations.
- Procure and distribute HIV rapid tests to static and mobile HCT sites

Expected impact and outcome from above allocation investment:

The financial crisis limits the extent to which HCT can be expanded, so the activities and benefits anticipated from the above allocation activities are focused on prevention, particularly around women's reproductive health and choices linked to the UNFPA initiative (Choices, not Chance). Outcomes expected from this are: Increased use of modern contraception, increased couple year protection rate, increased early access to ANC services, improved birth spacing and a reduction in low birth weight babies, stunting and maternal and neonatal deaths.

Module: Prevention Programs for adolescents and youth

2016		2017		Above allocation Total
Within Allocation	Above Allocation	Within Allocation	Above Allocation	
505,750	**6,638,400**	505,750	**6,638,400**	**13,276,800**

Target population & Geographical scope

Adolescents and youth, especially adolescent girls and young girls, in- and –out of school. Campaigns targeting in 18 provinces, outreach services targeted at hotspots particularly in 19 priority municipalities. *Note: 20% of outreach to young women out of school is within allocation.*

Prioritized above allocation interventions

- Community sensitization, community agents and other partners**.**
- Radio and TV campaigns, publicity spots
- Support NGOs and other partners (MINARS, MED, MINFAMU) in actions to promote empowerment, sexual and reproductive rights to adolescent girls in schools, colleges and universities.
- Support NGO's in development of programmes to promote empowerment, sexual and reproductive rights to adolescent girls and young women out of school.
- Conduct awareness campaigns and sensitization aimed at women of childbearing age for counseling and testing including in remote areas.
- Hold biannual meetings at national level for closer integration of national prevention actions of unwanted pregnancies in girls and women with HIV infection
- Link with ACS programme in HSS CN for youth friendly access and mobile services to trucking and mining hotspots for especially vulnerable communities.

Expected impact and outcome from above allocation investment:

Delay in sexual debut and reductions in inter-generational sex, sexual relations with more than one partner, teenage pregnancies, terminations of pregnancies, teenage maternal mortality, orphans, and Increases in couple year protection rate, use of modern contraceptives and access to youth friendly services.

Module: Prevention Programs for MSM & TGs

2016		2017		Above allocation Total
Within Allocation	Above Allocation	Within Allocation	Above Allocation	
143,150	**1,256,385**		**1,108,235**	**2,364,620**

Target population & Geographical scope

Nationally and priority provinces of Benguela, Luanda, Cunene, Cabinda, Huambo

Prioritized above allocation interventions

- Develop a national plan to respond to the HIV epidemic between KP including MSMs and TG
- Conduct sensitization training for health providers of target health facilities in Luanda (PEPFAR/USAID) and Benguela province to improve access to services of MSM & TG community and eliminate stigma and discrimination in healthcare setting

- Support local NGO to intensify community outreach and HIV/STI counselling and testing for MSM and TG populations via mobile clinics in municipalities of Luanda and Benguela
- Provide follow-up care through trained HIV counsellors and peer educators from the local NGO and support to HIV+ MSM and transgender to ensure adherence to treatment
- Synergy: Drop-In Centre specifically for MSM and transgender in the municipality of Rangel, Luanda for prevention, diagnostic and care and sensitize them on the services available (by PEPFAR/Linkages project).
- Procure and distribute condoms and water based lubricants.

Expected impact and outcome from above allocation investments:

Reduction in sexual relations with more than one partner in the target population and Increase in the use of condoms among MSMs and TG, and their partners, reduction in discrimination and stigma, increase in KP friendly services, improved health worker attitudes.

Module : Prevention Programs for other vulnerable populations: Truck drivers

2016		2017		Above allocation Total
Within Allocation	Above Allocation	Within Allocation	Above Allocation	
834,800	**641,641**	-	**641,641**	**1,282,000**

Target population & Geographical scope

Focused in 9 priority provinces where there are major transport routes and known hotspots

Prioritized above allocation interventions

- Intensify awareness work and training of health personnel that provide services around hotspots, seeking to increase testing and treatment of STIs in this population
- Train peer educators and staff and provide mobile clinics to provide prevention and testing services to truck drivers at identified hotspots
- Develop guideline for prevention and treatment for KP and vulnerable populations in Health Services (Friendly Services) including truck drivers.
- Develop and distribute IEC materials targeted at truck drivers and their partners.

Expected impact and outcome from above allocation investments:

Reduction in number of sexual clients in the target population and Increase in the use of condoms and early diagnosis of STI and a reduction of STI.

Module: Prevention Programs for other vulnerable populations: Miners

2016	2017

Within Allocation	Above Allocation	Within Allocation	Above Allocation	Above allocation Total
598,540	**641,641**		**641,641**	**1,880,540**

Target population & Geographical scope

Focused in 5 provinces where there are formal and informal mines and known hotspots

Prioritized above allocation interventions

- Intensify awareness work and training of health personnel that provide services around hotspots, seeking to increase testing and treatment of STIs in this population
- Train peer educators and staff and provide mobile clinics to provide prevention and testing services to miners at identified hotspots
- Develop guideline for prevention and treatment for KP and vulnerable populations in Health Services (Friendly Services) including miners.
- Develop and distribute IEC materials targeted at miners and their partners.

Expected impact and outcome from above allocation investment:

Reduction in number of sexual clients in the target population and Increase in the use of condoms and early diagnosis of STI and a reduction of STI.

Module: Prevention of Vertical Transmission (PMTCT)

2016		2017		Above allocation Total
Within Allocation	Above Allocation	Within Allocation	Above Allocation	
2,910,500	**237,000**	2,910,500	**237,000**	**474,000**

Target population & Geographical scope

Nationally. Target population includes:

- All pregnant and breastfeeding women identified as HIV positive while attending ANC, and labour wards,
- HIV exposed infants of pregnant including children 5-14 years and breastfeeding women with HIV infection,
- Male partners/couples.

Prioritized above allocation interventions:

- The PMTCT program will also leverage and prioritize use of the ACS supported in HSS concept note who are already present and providing community based care.
- TV and radio campaigns for education and behaviour change.

Expected impact and outcome of above allocation investment:

Reductions in unwanted pregnancies and terminations, HIV prevalence amongst pregnant women,and the rate of vertical transmission, stunting, low birth weight and SGA babies and increases in ANC (early) attendance, couple year protection rate, use of modern contraception, dual contraception, birth spacing

Module: Treatment , care and support

2016		2017		Above allocation Total
Within Allocation	Above Allocation	Within Allocation	Above Allocation	
6,520,463	**2,927,980**	7,615,244	**3,434,380**	**6,362,360**

Target population & Geographical scope

Benguela and surrounding referral catchment for viral load and 4 provinces for CD4 monitoring. All PLHIV.

Prioritized above allocation interventions

- Acquisition of viral load machine and kits
- Development of new laboratory including training staff and provision of related supplies
- Training network of referring staff on CD4 and VL
- Acquisition of CD4 machines and kits
- Training of staff on EID and provision of related kits and supplies

Expected impact and outcomes from above allocation investments:

Improved quality of diagnostic services and management of PLHIV. Reduced infections resulting from better viral load management.

Module : Health information systems and M&E

2016		2017		Above allocation Total
Within Allocation	Above Allocation	Within Allocation	Above Allocation	
-	**2,184,885**	-	**1,675,110**	**3,859,995**

Target Institutions and geographical coverage:

Central (INLS), Province and municipalities nationally

Priority above allocation interventions:

Routine reporting:

- Support for the revision of reporting tools to ensure data integrity,
- Develop and dissemination of data tools including printing,
- Training on the collection, aggregation and analyses of program data at province, municipal and facility level;
- Strengthening of electronic data management skills at municipality level.

Analysis review and transparency:

- Regular and joint supervision activities;
- Support the capture of HIV data in Municipal Health Information System,
- Support the review of the HIV M&E system to cater for both TB and HIV program indicators.

Data management capacity:

- Support capacity building on long and short team courses for Monitoring and Evaluation teams in the INLS,
- Procure TA for developing and costing the HIV Monitoring and Evaluation plan,
- Build capacity at the province and municipality level in data management and analysis.

Expected impact and outcomes from above allocation investments:

Availability of accurate and timely data and strategic information to inform decision making, prioritization and programming; strengthened capacity of INLS in information management systems, including systems for monitoring and evaluation, aligning information records in all sites, hospitals, and public private partnerships involved.

TB-HIV Collaboration

Module: TB/HIV co-infection

2016		2017		Above allocation Total
Within Allocation	Above Allocation	Within Allocation	Above Allocation	
345,263	**1,634,826**	439,918	**1,900,721**	**3,535,547**

Target population & Geographical scope

Nationally. Target population include all TB and HIV patients..

Prioritized above allocation interventions:

- Training of staff in provincial laboratories and in prisons in 18 provinces.
- Supervision of staff in laboratories
- Study on HIV/TB coinfection in prisons
- Provision of IPT to PLHIV who are TB negative

Expected impact and outcomes from above allocation investment:

Reduced morbidity and mortality among TB/HIV co-infected patients; improved survival rate of TB/HIV co-infected patients; reduction in number of patients with TB/HIV co-infection.

TB Modules

In the TB modules the above allocation activities expansions of the within allocation activities and so the impacts described are attributed proportionally to above allocations funding.

Module: TB care and prevention

2016		2017		Above allocation Total
Within Allocation	Above Allocation	Within Allocation	Above Allocation	
2,209,894	**907,086**	3,700,288	**1,196,057**	**2,103,143**

Target population & Geographical scope

Nationally, focusing on staff in municipal facilities in priority provinces with the highest defaulter and lowest treatment success rates for system strengthening DOT C programme.

Prioritized above allocation interventions

TB management in facilities:

- Training nurses in provincial facilities in TB management and use of data tools.
- Monitoring and supervision from national to provincial and provincial to municipality levels.
- Meeting and national level for analysis and review.

Community TB care delivery:

- Training additional ACS for the expansion of the DOTS C programme.
- Provincial management meetings for DOTS C programme.
- Supervision of DOTS C ACS

Strengthening laboratories:

- Development and printing of guidelines.
- Acquisition of laboratory equipment and consumables for GeneXpert and cultures.

Vulnerable populations - Prisoners:

- Training of prison staff for TB/ HIV management
- Supervision of prison staff and laboratories.

Expected impact and outcomes from above allocation investments:

Broad increase in quality of TB services, including laboratories. 30% expansion of facilities with trained and supervised staff and 150% expansion of DOTS C programme

Module: Multi-Drug Resistant TB (Diagnosis and treatment)

2016		2017		Above allocation Total
Within Allocation	Above Allocation	Within Allocation	Above Allocation	
345,503	**950,545**	380,865	**211,957**	**1,162,502**

Target population & Geographical scope

Nationally, staff in MDR TB referral networks.

Prioritized above allocation interventions:

- Training of specialist staff as provincial focal points for MDR TB management
- Training of doctors and nurses in MDR TB diagnosis and management in reference centres and municipalities to develop the referral networks in all 18 provinces.
- Training of staff in provincial referral laboratories
- Supervision of the MDR networks.
-

Expected impact and outcomes from above allocation investments:

60% of the improved outcomes in facilities are estimated to be from above allocation investment. Improved case detection, earlier and rapid diagnosis and management of MDR TB, improved referrals and access to a referral network in all provinces. Lower mortality from MDR TB

Module: Health information systems and M&E

2016		2017		Total
Within Allocation	Above Allocation	Within Allocation	Above Allocation	
449,431	**1,065,851**	549,955	**1,015,371**	**3,080,608**

Target Institutions and geographical coverage:

National (PCNT), Province and municipalities

Priority Interventions

- Provision of IT and communications equipment through HSS CN HIS module in priority municipalities.
- Develop and dissemination of data tools including printing,
- Training, collection, aggregation and analyses of program data at the municipal and facility level;
- Strengthening of electronic data management skills at municipality level.

Expected impact and outcome

Availability of accurate and timely data and strategic information to inform decision making, prioritization and programming; strengthened capacity of PNCT information management systems, including standardized records in the TB information system in 75% of DOTS centres

3.4 Focus on Key Populations and/or Highest Impact Interventions

This question is <u>not</u> applicable for Low Income Countries.

For TB and HIV, describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:

a. If the applicant is a lower-middle income country, describe how the funding request focuses at least 50% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

b. If the applicant is an upper-middle income country, describe how the funding request focuses 100% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

1 PAGE SUGGESTED

The funding request has focused 100% of the budget on the following as described below:

i) *Underserved:* The HIV modules have targeted the following underserved populations: a) Key population for prevention services (MSM & TG, FSW, Truck drivers and miners). b) Children for ART services. c) PLHIV for TB screening and IPT. The TB modules have targeted the following underserved populations: a) Prisoners. b). c) Geographically underserved areas. d) Populations with MDR-TB.

ii) *Most at risk populations*: For HIV/TB modules the request has focused on the most at risk and vulnerable groups as demonstrated by the epidemiology. For HIV priorities for the request are: a) MSMs &TG. b) FSW. c) Truck drivers. d) Miners. e) Adolescents, young girls and women. For TB modules, the request had dedicated resources to the following a) Prisoners. B) HIV-TB coinfected patients.

iii) *Highest impact interventions:* The request has focussed on evidence based and proved high impact TB/HIV interventions. For HIV modules, these include a) PMTCT (Option B+) b) ART. c) EID and Viral load monitoring. d) Management of TB/HIV co-infection. e) Cotrimoxazole prophylaxis. For TB modules, these include a) TB case finding and detection. b) TB treatment for susceptible individuals. c) MDR-TB. d) Management of TB/HIV co-infection. E) Isoniazid prophylaxis.

SECTION 4: IMPLEMENTATION ARRANGEMENTSAND RISK ASSESSMENT

This section requests. Information regarding the proposed implementation arrangements for this funding request. Defining the implementation arrangements for the program including the nominated Principle Recipients (PRs) and other key implementers is essential to ensure the success of the programs and service delivery. For the concept note for TB and HIV, the Country Coordinating Mechanism (CCM) can nominate one or more PRs, as appropriate given the country context**.**

4.1 Overview of Implementation Arrangements

For TB and HIV (including HSS if relevant), provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector PRs).

b. If more than one PR is nominated, how co-ordination will occur between PR(s) for the same disease and across the two diseases and cross-cutting HSS as relevant.

c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipient(s) have been identified.

d. How coordination will occur between each nominated PR and its respective sub-recipient(s).

e. How representatives of women's organizations, people living with the two diseases and other key populations will actively participate in the implementation of this funding request.

2-3 PAGES SUGGESTED

A. Dual-track financing arrangement (i.e. both government and non-government sector PRs).

The CCM has decided to use double track financing for this TB/HIV CN.The two PRs were chosen in a competitive selection process. Five organizations out of nine that applied for the role of Principal Recipient on HIV/TB grant in May 2015 were eligible. The Principal Recipients were determined based on written evaluations by each CCM members an open evaluation process. Ministry of Health (MINSA) was selected as PR1 and UNDP as PR2 in the view of complementing each other for a best possible grant implementation.

PR1 and PR2 on the HIV/TB complementing synergies that offers competitive advantages of the respective modules in their work to jointly oversee results.

*Experience of PR 1***:** UTG is well established in the MoH and has been a PR since 2009. It has experience working with a number of governmental agencies. PR1 has built capacity in financial management working with a Big4 company and is committed to strengthening all areas of project management practices as per LFA recommendations. PR1 has shown good results implementing both the malaria and the TB grant

*Experience of PR 2***:** UNDP has in-country experience of 11 years of grant

implementation between 2004-2015. UNDP has an existing HIV unit with procurement, M&E and monitoring function and a capacity development. Apart from the Global Fund portfolio, UNDP has been implementing its own programs in the area of HIV.

B. Co-ordination between PR(s) for the same disease and across the two diseases and cross-cutting HSS

The coordination of both PRs will be ensured through an integrated plan approved by CCM and that will establish the compliance of objectives and goals of the concept note based on standard Global Fund procedure and best practices of international technical and financial management.

There will be joint work plans for PR and SRs across the TB/HIV programs and the cross cutting HSS modules. There will be a joint database for consultants and a shared document database will be used as well as joint and terms of reference for monitoring visits and SOPS for financial management. The PRs will jointly hold regular meetings with stakeholders including civil society to debrief on the status of grant implementation.

PRs will elaborate and submit to the Global Fund the PUDR – Project Update/Disbursement Request – according to the schedule and requirements defined by the Global Fund. PRs will be at disposal to the LFA for PUDR reviews or other ad hoc reviews or verifications. PRs will report regularly, at least quarterly to the CCM on the performance of the grant and will submit an annual report to the CCM as well.

The PRS will establish a financial reporting schedule with MINSA, INLS and PNCT according to the Global Fund requirements and will build the capacity to provide high quality and timely programmatic and financial reports. Recruitment of program staff will be conducted by a joint recruitment committee.

In this grant the PRs will be encouraged to meet regularly to: discuss procurement needs; forecast requirements; work out logistical arrangements; share lists of potential SR recipients to ensure no double funding occurs; share reporting formats; align processes and procedures; and, discuss programmatic challenges.
The PRs will be encouraged by CCM Secretariat to routinely communicate with each other to ensure they are able to respond effectively to any challenges that arise. Where issues and gaps arise, the PRs will be encouraged to work together to ensure the needs of the national response are met.

The PRS will be encouraged to have a MOU for coordination platforms between the two PRs, across which information and resources will be shared. The two PRs from the government and non-government sectors will enhance the public-private partnership approach by resources with the private sector and coordinating training and M&E.

C. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipient(s) have been identified.

The lead SRs designated for this concept note are INLS for UNDP and PCNT for TUG. The lead SR have been selected as the main implementers since previous grants and have been assessed routinely to ensure that they still possess the capacity in managing and implementing GF grants among others.
The PR and SR will sign a MOU stipulating the roles and responsibilities of each party. Each SR will develop a set of work plans as per the grant, aligned with the National Strategic Plan (PEN-HIV and PEN-TB), performance framework (PF) and outlined implementation arrangements which will be used as monitoring tools by the PR to monitor their progress. Additional disbursements will be a performance based to ensure that the set targets in the PF are been met.

PRs will disburse money to SRs on a quarterly basis based on the submission of programmatic and financial reports and in conformity with the approved budget. To verify the SR expenses, PRs will conduct on site visits with verification of supporting documents.

The PR will have planned capacity building visits on quarterly basis to the SR to ensure that their management capacity is enhanced. This will include areas of finances, M&E, PSM and program management. All SR will be subjected to financial audit by the PR in addition to their internal audits annually.

D. How coordination will occur between each nominated PR and its respective sub-recipient(s).

PR coordination

The CCM provides oversight to the portfolio of Global Fund grants in the country. It is tasked with the responsibility of ensuring coordination of the PRs; and measuring and monitoring performance of the grants. The CCM provides a high-level formal and representative forum for all the partners from government, private sector, development partners, civil society, including international NGOs, People leaving with diseases (PLWD) and Key population. The CCM provides a platform for information sharing, technical leadership and direction.

The CCM coordinates the PRs through their quarterly meeting and different visits to produce reports outlining their progress, challenges and programmatic information relevant to CCM on Finance specifically in regards to where is the Money in terms of Procurements to know and be aware where are the drugs or other products; Implementation to see if the grant is being implemented on schedule and how programme is doing in terms of the targets; Technical Assistance to deal with any bottlenecks and technical assistance required to solve various issues arise.

These reports are presented to the CCM members in their scheduled quarterly meetings to provide feedback and strategic direction on how the grants are performing and if there are any bottlenecks necessary steps and remedies are suggested to the PRs by the CCM.
In case of any urgent matter needed to be resolved there is a mechanism in place for calling an extra ordinary CCM meeting to discuss and resolve the issue before the CCM scheduled meeting time.

SR coordination

Ministry of Health has put in place a functioning PMU to strengthen the relationship with its SRs and manage its performance. The PRs have developed their own monitoring and evaluation frameworks and through the PMU that is comprised of M&E, grants accountant, PSM expert and procurement manager who work closely with the SRs coordinating the implementation of their grant agreements. The PMU does its role through quarterly meetings and visits to the fields to ensure that the grants are in progress as planned. The PMU also participate in the meeting of SRs committees to get updates and be involved in different SR planning sessions to provide strategic leadership and direction.

D. How representatives of women's organizations, people living with the two diseases and other key populations will actively participate in the implementation of this funding request.

A wise scope of stakeholders and organizations, representing the public and private sectors, civil society, women groups, FBOs and partners involved in the national HIV and TB response are organized into self-coordinating groups, platforms and forums representing key constituencies such as PLHIV, KPs, Ex-TB groups, youth, and other

interest groups. These groups were involved in the country dialogue for the development of this concept note. There has been full involvement of different key stakeholders throughout the concept note writing process.

Through ANASO these groups will be on board during the implementation as Sub-sub recipients (SSR) of this grant. ANASO communicates within the context of the existing institutional framework of the Provincial and Municipality Coordinating Committees and coordinates them in terms of convenes quarterly meetings with the groups, platforms, and forums to facilitate partnership building, consultation, participation and information exchange among the various SSR. MINSA has established the framework within which these groups operate to ensure a harmonized, focused and cohesive national HIV and AIDS response.

4.2 Ensuring Implementation Efficiencies

Complete this question only if the CCM is overseeing other Global Fund grants.

From a program management perspective, describe how the funding requested links to any existing Global Fund grants or other funding requests being submitted by the CCM at a different time. In particular, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

1PAGE SUGGESTED

Currently the CCM is managing GF funds for TB only; there are no other program funds in the country.

Both Malaria and HSS are linked and aligned with this TB/HIV Health System CN which help leverage resources to remove barriers identified by the TB/HIV. Specifically cross cutting modules of information systems, pharmaceuticals logistics and health work force at the community level. CCM and the disease programme technical working groups have worked together to ensure that the disease CN activities relate to the focus of the HSS CN in order to derive maximum benefit from the HSS.

MINSA are PR on the HSS, HIV/TB and Malaria CN. Apart from the disease specific supervision, they will combine the resources for the management of the 2 components of the grant management.

World Vision are a PR only on this HSS CN

UNDP are a PR only on the HIV/TB CN

The M&E component of this CN is also complementary to and aligned with the HSS CN

4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery

For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.

PR 1 Name	Ministry of Health of Angola	**Sector**	**GOV**
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?		X☐Yes ☐No	
Minimum Standards		**CCM assessment**	

1. The Principal Recipient demonstrates effective management structures and planning	*Yes. The Principal Recipient as Health Governmental institution has an undisputed Jurisdiction to receive funding coming from the Global Fund and execute the management PNCT and AIDS Programme* *Ministry of Health has departments to support different programs in planning and M&A.*
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)	*Yes, Ministry of Health has a defined administrative structure organizational chart there is a Study Office, Planning and Statistics that oversight and all Health activities. Therefore the implementation of the activities will be regularly supervised and monitored by the PR1, which receives all the reports from Sub Recipient.*
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	*The MoH has past experience in setting periodic internal reviews of financial management. This will be presented during the meetings of the CCM in order to monitor the situation. If it is needed, a deep investigation with external entities will be conducted using external consultants.* *The PR1 has been encouraged by the Global Fund to invest in an efficient system to the application of internal audits, which was previously done. The PR1 has been using the PRIMAVERA software system to manage the information and prevent programme risks management.*
4. The financial management system of the Principal Recipient is effective and accurate	*The MOH with past experience will improve the management to make it more effective. The PR1 has been using the PRIMAVERA*

	software recommended by the Global Fund.
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	*There is a central store with capacity for proper management and appropriate logistics.* *At provincial level, there are stores but there remain internal logistical problems to be resolved.*
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions	*For the logistics is provided , which is a central purchasing and procurement of drugs and medical products at national level. In the provinces, the same system is used. Purchases are made on the basis of SRs program annual plans.*
7. Data-collection capacity and tools are in place to monitor program performance	*The PR1 and the SRs have tools and M&E Plan to monitor the Programme Performance* *The PR1 and SRs has forms and a computerized information system. Ongoing training and supervision training contribute to a strengthening of filing and reporting of data. Has recording systems, reporting and computerized information systems in regular use.*
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	*The PR1 and SRs has the routine surveillance Systems and produce regular and periodic reports on the Program Performance sent to PR, LFA and the GF* *The SRs has a system, the operational part of which has problems regarding the prompt submission of data. Has a functional system.*

9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	*Yes. The PR1 has technical capacity to ensure the M&A quality control and monitor the health product quality t*hroughout *the National Direction of Drugs and Equipment.* *SRs has technical capacity but with limited financial resources to make periodic field visits.* *SRs comply with the supervision schedule at all levels and carries out continuous analysis of the situation.*

4.3 Minimum standards for the main beneficiaries and the implementation of the program

For both tuberculosis and HIV, fill in the following table for each nominated principal recipient For more information about the minimum standards, see the Concept Note instructions.

Name of PR 2	UNDP	**Sector**	**ONU**
Does this PR currently manage Global Fund grants for this disease component or independent grants for crosscutting interventions for strengthening health systems?		X☐ Sí ☐ No	
Minimum standards		**CCM Evaluation**	
1. The Principal Recipient demonstrates the effectiveness of their management structures and planning.		*UNDP has a clear and effective management structure and implies thorough processes for planning. Institutional and Programmatic arrangements include: effective organizational leadership, management, transparent decision making and accountability systems; and adequate infrastructure and information systems to support programmer implementation.*	
2. The Principal Recipient is trained and has the necessary systems for effective administration and supervision of sub-recipients (and relevant sub-sub recipients).		*UNDP has defined processes for sub-recipients management and possesses vast experience with sub-recipient management. The UNDP SR management toolkit is recognized by the Global Fund and used systematically in all countries.*	
3. The internal control system of the PR is effective for the detection and prevention of fraudo r embezzlement.		*UNDP has a rigorous internal control system as stipulated in the Internal Control Framework, Program and Operations Manual and Procurement Manual. UNDP applies zero tolerance policy to fraud. The Internal Control Framework (ICF)*	

	guides the segregation of duties. Each function has clear roles and responsibilities as laid out in the ICF. This is supplemented by controls enforced by the Atlas accounting system used by UNDP. The software is an integrated application which links grants management, procurement, human resources and finance modules.
4. The financial management system of the PR is effective and accurate..	*UNDP has well defined processes regulating financial management which include. recording all transactions and balances, including those supported by the Global Fund; preparation of regular reliable financial statements; safeguarding PR and SR assets; and systems to disburse funds to Sub-recipients and suppliers in a timely, transparent and accountable manner; management and facilitation of SRs' financial reporting as well as annual auditing.*
5. The central store and the regional store have sufficient capacity and follow recommended practices regarding storage to provide appropriate conditions, integrity and security for health products.	*The ARVs and health products procured by UNDP are stored at Neofarma, a warehouse approved by the GF. UNDP implements a Quality Assurance Plan which includes assessment of conditions of provincial and municipal warehouses and improving the conditions, including installation of thermometers.*
6. Agreements about the systems of distribution and transport are effective and ensure the continuous and secure supply of health products to end users, avoiding interruptions in treatment or in the program.	*Distribution is managed by the INLS with the technical assistance of UNDP. UNDP also provides technical assistance to the INLS/PNCT in stock management.*
7. Availability of capacity and data collection tools to monitor program performance.	*UNDP has an extensive monitoring and evaluation capacity and works towards a robust monitoring system through effective policies, tools, processes and systems. UNDP has extensive experience and capacity in obtaining reliable data and information for monitoring programmers performance, which is part of routine processes in its programming practice as well as in its technical and capacity development support. UNDP uses data provided by the national system to report on indicators. UNDP works together with the INLS/PNCT on improvement of data collection tools and data quality.*
8. Availability of systematic and functional reporting system with sufficient coverage to promptly and accurately report on program performance.	*UNDP has a well established reporting system within the organization as well as with the sub-recipients to provide timely and quality reports.*
9. The implementing agencies have the ability to meet quality	*UNDP procures ARVs and health products from verified sources. UNDP has been implementing*

requirements and monitor product quality throughout the supply chain in the country.	*Quality Assurance Plan which includes a quality control component where medicaments are being tested.*

4.4 Current or Anticipated Risks to Program Delivery and PR(s) Performance

a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, PR(s)and key implementers' capacity, past and current performance issues.

b. Describe the proposed risk mitigation measures (including technical assistance) included in the funding request.

1-2 PAGES SUGGESTED

Three grants need to be implemented parallel and in a harmonized manner during the short duration of 24 months This all while at the same time the governmental ability to complement Global Fund monies has been diminished due to fall of oil price by 50% or more. The hiring freeze at MoH at all levels with some contracts being cut short is a further aspect of the implementing environment. Another significant issue are difficulties in using hard currency due to official and unofficial hard currency restrictions**.**

The main recipients have executed grants before, with PR1 being currently supported by a Big 4 company in financial management. Issues of bank account reconciliation and internal/external audit have been raised as major risks for PR1. PR1 programme structure and operations will be reviewed during the next months.

The implementing partner INLS has good project management function and experience. This is not the case of PNCT, who has requested support in programme management through the current note because its structure is relatively weaker than that of INLS

The bottlenecks for implementation may arise as:

- Slow disbursement process
- Lack monitoring and Evaluation staff on local levels
- Regular stock out of mains data collect tools on local levels,
- Deficient data collection tools usage.
- Limited supervision at the operational level;
- Low quality of data (inconsistency),
- Non-compliance with national guidelines at local level
- Lack of funds for supervision from provincial level

The CCM wil be coordinating the establishment of risk management plan. UNAIDS and WHO will support the process from the technical side
A strong training plan of M E focal staff will be all level. A part of this plan will be funded by the Global Fund NC

UNDP as a PR has gone through regular reviews by LFA and through audits with satisfactory results. UNDP has a strong internal control policies. In terms of procurement,

UNDP is procuring from verified and pre-qualified sources and is implementing a Quality Assurance Plan to ensure the quality of medicaments. No procurement will be undertaken on the TB side with the GF monies, which may cause bottlenecks in reaching the targets in case drugs and health products were not available. Regular meeting of the quantification group are planned.

The CCM has a supervision plan allowing it to regularly monitor the implementation of activities at all levels (SRs, PRs and other partners involved), through CCM meetings and its technical group.

The TB / HIV will strive for more visibility in the political agenda of the Ministry of Health - and commitment at the highest level, ensuring support to programs centrally to the peripheries.

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

☐	Table1: Financial Gap Analysis and Counterpart FinancingTable
☐	Table2: Programmatic Gap Table(s)
☐	Table3: Modular Template
☐	Table4: List of Abbreviations and Attachments
☐	CCM Eligibility Requirements
☐	CCM Endorsement of Concept Note