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Consolidated Z Grant - Angola

NARRATIVE PROPOSAL FOR THE REPROGRAMMING AND REVISION OF PROGRAMMATIC INTERVENTIONS UNDER THE NFM 2 MALARIA, HIV AND TB GRANTS, JULY 1, 2020 TO JUNE 30, 2021

Approved by GF on: May 14, 2020

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Background and Rationale

This Narrative serves to introduce the submission of the Performance Framework, Budget, List of Health Products and Implementation Map by UNDP to the Global Fund for the consolidated Z grant, covering the last year of the NFM 2 grants for TB, Malaria and HIV (period of July 2020 to June 2021). The Narrative summarises the country's current performance against the various NFM 2 grant indicators, as per the latest PUDRs, and presents the proposed strategies and interventions to improve those indicators in the remaining 12 months of NFM2. These strategies were developed with the National Disease Programmes as sub-recipients (SRs), and UTG as outgoing PR, with careful consideration of TRP and OIG recommendations received across the three disease programs. The Narrative also aims to respond to the Global Fund request to use the last year of NFM 2 to prepare and introduce its newly designed sub-national approach for Angola. It is therefore inspired by the following principles:

a) **Ensuring continuity** as to meet the grant performance targets agreed with the Global Fund. To convey the fact that the Z Grant is still part of NFM 2, the Narrative uses an updated version of the contextual information provided to the Fund at the time of submission of Angola's HIV, TB, Malaria and RSSH funding requests (2017, 2019). More importantly, it responds to the need for both UNDP ad the Global Fund to exit responsibly from the fourteen (14) provinces which have not been selected by the Fund for the sub-national approach under NFM 3 as well as prepare for exit the civil society organisations (CSOs) and vulnerable populations who will see a reduction in funding in NFM 3.

b) **Preparing for NFM 3 and the sub-national approach** through 1) the prioritisation of Benguela province, 2) geographically focused capacity development so as to improve quality of service delivery at decentralized level, and 3) strategic investments in health systems strengthening.

Epidemiological Updates

HIV

Prevalence data

Relatively recent epidemiological data is now available in Angola thanks to the 2015-2016 Multiple Indicators Survey (MIS) and Demographic Health Survey (DHS)[1], the 2015 SADC-sponsored study on the *Prevalence of HIV, Biological and Behavioural factors of Infection between Female Sex Workers (FSW) in Benguela and Luanda* (2016) and the USAID/LINKAGES-supported IBBS study among Key Populations (KP, 2016)[2]**.** While national HIV prevalence is at 2%[3], it varies aamong the country's 18 provinces, between 0.5% (Zaïre) and 6.1% (Cunene). 7 provinces, mostly bordering high prevalence countries are characterised as presenting a high disease burden. As far as gender differences are concerned, a higher prevalence is seen among women (2.6%) compared to men (1.2%) aged 15-49 year old. 1.5 % of 15-24-year-old Adolescent Girls and Young Women (AGYW) are living with HIV compared with 0.8% of adolescent boys and young men of the same age group**.** Among young women aged 20-24, the prevalence rises to 2.1%, which is considered high for that age group. The LINKAGES Study found a prevalence of

[1]MIS and DHS conducted with technical and financial support from USAID, World Bank and UNICEF (2016).

[2] Programmatic Mapping and Prevalence of HIV and other STIs among Key Populations of Angola: PLACE 2017. Conducted with USAID/PEPFAR technical and financial support.

[3] Source: Angola IMMS 2017

7.8% among FSW, 2.4% among men who have sex with men (MSM) and 9% among Transgender Women (TG).

Data from unique KPs tested over 4 years (n=45,760) by the USAID/LINKAGES programme, found an overall case finding rate of 5% with significant variabilities by group and location: 4.2% for FSWs, 5.7% for MSM and 39% among TG in Luanda province. In Bié, the HIV case finding rate among FSWs was 10% and 5% for FSWs between the ages of 15 to 24.

These data therefore suggest that young women aged 15-24 years and KP are disproportionally affected by HIV.

Malaria

Malaria continues to be the principal cause of morbidity and mortality in Angola with the entire population being at risk of infection. Malaria is endemic all over the country and transmission occurs all year round. However, according to the DHS[4], the geographical distribution of malaria has changed from the north east to the east of the country, especially Moxico (40% prevalence) and Cuando Cubango (38% prevalence), which are provinces bordering Zambia and Namibia. In Benguela, the prevalence estimated in the DHS was 10%. **Most vulnerable are children under 5 years of age and pregnant women** particularly in rural areas as access to public health services varies significantly across the country and within provinces, with a national average of 44.6%[5]. Malaria accounts for 35% of mortality in children, 25% of maternal morbidity and 60% of hospital admissions in children under 5 years of age and 10% of admissions of pregnant women[6]. The National Malaria Strategic plan, (Malaria-PEN) 2016-2020, focuses on reaching those vulnerable groups.

Tuberculosis

In 2018, TB Incidence rates were estimated to be 355/100,000. In 2019, in Benguela, a priority province for this grant, WHO's incidence rate is higher at 467/100,000. WHO estimates MDR-TB prevalence at 2.4% in new cases and 15% in previously treated cases. Additionally, 10% of TB patients are estimated to be co-infected with HIV. However, only 39% of TB patients who know their HIV status are on ART, a proportion that has not changed between 2017 to 2019[7]. Only 42% of new HIV patients in whom active TB has been excluded are enrolled in Isoniazid prophylaxis treatment (IPT)[8]. This situation is considered to be an underestimation due to lack of timely and complete data coming out of health facilities nor being analysed on a timely basis to inform the programme.

Policy updates

The Z grant will help achieve Angola's Sustainable Development Goals (SDG) targets by contributing to the implementation of its 5-year National Development plan (PND, 2018-2022) as well as the revised National Health Development Plan (PNDS, 2018-2025). The four programme areas defined by the Ministry of Health for its contribution to the NDP are 1) improvement in health care (medical and pharmaceutical); 2) improvement in maternal and child health; 3) Control of the great epidemics through a social determinants of health approach; 4) Strengthening the health information system and developing health research and investigation. The **Provincial Health**

[4] Demographic Health Survey 2016.

[5] Plano Nacional do Desenvolvimento da Saúde, PNDS, 2012-2015).

[6] World Malaria Report 2015.

[7] 1,093 of 2,829 co-infected patients were reported on ART in the second half of 2019. TB PUDR, Jul-Dec 2019.

[8] WHO, 2019 Global TB Report.

Development Plan (PPDS 2018-2025) for the target province of Benguela will also be inform the design and implementation of the Benguela-based interventions.

Over the past five (5) years, significant investments have been made in creating **an enabling environment for HIV, TB and Malaria programmes in Angola**. The following table lists the most critical policies, plans, guidelines and other instruments which now exist at national level, thanks the Ministry of Health efforts and the technical and financial support of its partners. Many of these instruments were generated with Global Fund support, through NFM 1 and NFM 2 grants. Collectively, they also inform the implementation approaches which are hereby proposed.

Table 1: Major Policy and/or structural milestones reached and related to creating an enabling environment for HIV, Malaria and TB Programmes in Angola

Policy/Structural Milestone	Adoption Year
Malaria	
National Policy for Community Development and Health Workers (PANADECOS), elaborated (approved in 2018)	2014
Adoption of integrated community case management of malaria (ICCM) through ADECOs.	2016
Update of the norms and protocols for intermittent preventative treatment during pregnancy (IPTp).	2016
New National Strategic Plan, 2016-2020.	2016
Inclusion of Malaria Indicators into the DHIS2 System.	2017
Adoption of the PANADECOS Policy, which officially includes Community Development and Health Agents (ADECOS) as a remunerated cadre within the health system (in partnership with the Ministry of Territorial Administration).	2018
HIV	
Design, piloting, dissemination of new HIV and TB Programme data collection instruments.	2016-2018
Completion of the study funded by SADC on the Prevalence of HIV, biological and behavioural factors of infection between female sex workers (FSW) in Benguela and Luanda	2016
Adoption of Test and Treat (WHO, 2015).	2017
HIV testing without parental consent allowed for AGYW by the INLS, when a) AGYW is sexually active (already has children or is pregnant); b) suffers sexual exploitation or c) there is evidence of homelessness.	2017
Completion of the first Integrated population-size estimate and IBBS of HIV, Chlamydia, Gonorrhoea, Syphilis and Trichomonas prevalence among MSM, Trans Women, FSWs in the provinces of Luanda, Bie, Benguela, Cabinda and Cunene.	2017
Assessment of M&E and Data Quality in Angola, Cohort 2017	2018
Independent assessment of the AGYW programming under the Global Fund HIV grant.	2018
New National Plan for the Elimination of mother-to-child transmission of HIV, syphilis and hepatitis B.	2018
Inclusion of HIV Indicators into the DHIS2 System.	2018
Drafting of the National Strategy for Vulnerable and Key Populations; the Situation Analysis for Key and Vulnerable Populations; the Guidelines for Health Professionals working with Key Populations.	2018

Policy/Structural Milestone	Adoption Year
Adoption of WHO 2016 recommendations into the National STI guidelines for providing treatment for chlamydia and gonorrhoea presumptively to FSWs.	2018
Launch of HIV Legal Environment Assessment Report.	2019
Publication of the new Penal Code which removes language that tacitly categorised homosexuality as a "crime against nature" and includes discrimination on the basis of sexual orientation as a crime.	2019
New HIV National Strategic Plan, 2019-2024.	2019
Adoption of a National List of Community Monitoring Indicators.	2019
Adoption of Transition Plan for TLD.	2020
TB	
Adoption of new Treatment protocol for drug-susceptible TB and patient care guidelines.	2016
Use of high impact interventions (GeneXpert), ultra-cartridges for suspected MDR-TB; diagnosis of TB-XMR with solid and liquid culture; molecular test of LPA.	2016
Adoption of shorter regimes (9 months) for MDR/R-TB including new drugs such as Bedaquiline and Delaminid for eligible TB cases.	2016
Strengthened community TB care activities to increase case notification rates (CNR) and treatment success rates (TSR).	2016
Established in PNDS (2018-2025) that C-DOT be implemented in every municipality	2018
Adoption of One-stop-model by Ministerial decree	2018
Decentralisation of TB diagnostic services by Ministerial decree	2018
New TB National Strategic Plan (2018-2022)	2018
Data collection instruments for TB, revised and updated; to be included into the DHIS2 System in 2020.	2019
National Health Information System	
Review of the National Health Information System (SIS)	2016
Selection of a HIS system and publication of a 2-year roadmap for the *Demographic Health Information System Two* (DHIS2)	2018
Expansion of DHIS 2 in 6 provinces (Kwanza Norte, Lunda Norte and Sul, Malanje, Uige and Zaïre) with funding from USAID/PSI Health for All Project, and the World Bank.	2019
Agreement with the main private telecommunications company in Angola signed to facilitate transmission of DHIS 2 data.	2019
National Procurement and Supply Management System	
National Quantification Committees for HIV, malaria and Tuberculosis established with USAID and UNDP support.	2015
National Strategic Plan for the Supply Chain (PENECA, 2016-2021)	2016
Development of an OpenLMIS roadmap with technical and funding support from the USAID Global Health Supply Chain – Procurement and Supply Management (GHSC-PSM) Project.	2017

Policy/Structural Milestone	Adoption Year
Launch of Ministry of Health pooled procurement initiative ("compras agrupadas"), using the electronic procurement platform managed by the Ministry of Finance.	2018
Ministerial decree, which decentralizes activities related to pharmaco vigilance	2018
Implementation of OpenLMIS in 8 Provinces (Benguela, Luanda, Lunda Norte, Lunda Sul, Malanje, Kwanza Norte, Uíge and Zaire) with support from GHSC-PSM Project.	2019-2020

Health Information Management System challenges

Despite these important milestones, the following diagnostic made in 2016[9] remains:

- Insufficient health service coverage and quality of care;
- Weak referral and counter referral systems between the three levels of the National Health service;
- Insufficient human resources in terms of quantity and quality as well as unequal distribution between urban, peri-urban and rural areas;
- Weaknesses in health management systems, including health information system, logistics information system and internal and external communication systems;
- Insufficient financing and inadequacy of financing models;
- Weak collaboration within the health sector and with other sectors.

The health sector has now officially opted for DHIS2 as the main health data repository tool to aggregate statistical data collection, validate and analyze data, manage and report all health information for decision making. However, the TB module has yet to be created and WHO's 2018 guidelines need to be reflected as well. Additionally, the country does not have an integrated M&E Plan. Disease Programmes either have out of date M&E Plans (HIV and Malaria) or simply do not operate based on an M&E Plans (TB). The Angola Strategic Health Information System Plan (PESIS) 2011-2015 also identified the challenges specific to the National Health Information System[10]. These are described further in this document as part of the Z grant operating context under the RSSH module.

Procurement and Supply Management System (PSM) challenges

The PSM context in Angola is marked by a range of capacity gaps, identified by the Ministry's development partners through their respective assessments[11].

Governance, Leadership and Coordination

- The National Strategic Plan for the Supply Chain (PNECA 2016-2021) has not been validated and by and large not implemented;
- Within the MOH, there is not a department, unit or team in charge of the visioning, leadership and implementation of a national strategy on PSM from pharmaceutical legislation to procurement to warehousing and distribution. As a result, coordination among Ministry of Health departments and among Development partners involved in PSM is lacking, in their support to procurement as well as in their supply management. UNDP recently (2019) called

[9] 2016 Review of the Health Sector

[10] PESIS (2011-2015) page 1

[11] UNDP, 2020; World Bank, 2018; USAID, 2017

on its partners to create a partner coordination forum which will engage with the Ministry on PSM issues.

Quantification

- The work of the National quantification committees for HIV, malaria and Tuberculosis is limited by the lack of reliable data on morbidity and consumption at health facility, municipal and provincial levels;
- Procurement plans are hampered by delayed funding, particularly Government counterpart financing, at a time when Global Fund funded procurement has reduced significantly;
- Capacity for quantification, forecasting of needs, analysis of consumption data and inventory management is limited at all levels[12].

Procurement

- The cost of health commodities to the patient remains extremely high in Angola due to a combination of factors i.e. absence of a stringent Drug Regulatory Authority; lack of familiarity and non-use of Trade Related Aspects of Intellectual Property Rights (TRIPS) flexibilities; lack of competition and reliance on local importers;
- The Government entity in charge of procuring medicines, CECOMA, is undergoing governance challenges. Established in 2011, CECOMA is a public, autonomous institution (CMS)[13] which procures, stores and distributes health products for the public sector. After a series of nominations and replacements, the position of CECOMA Director has remained vacant over the past 24 months.

Warehousing

- CECOMA does not have an effective warehouse or inventory management system, including written procedures. The existing software, created with support from the Cuban bilateral cooperation, does not address the entirety of CECOMA needs. The latter continues to face challenges in controlling its inventory, in managing goods received and delivered, expiration dates and quarantined products;
- In addition to its 18 provincial warehouses, the country has 4 regional warehouses (Benguela, Huila, Malanje and Luanda provinces). However, access to uninterrupted supply of energy for product stability and maintenance of cold chain remains problematic. An assessment of 6 provincial warehouses conducted by the INLS UNDP in 2018[14] found out that the majority requires infrastructure rehabilitation. Also newly acquired equipment such as air conditioning or fire extinctors, had not been installed. And even though the newly built regional warehouses have a larger capacity and modern equipment, they have been left unused since their construction (2015) and have therefore been vandalised. Following this assessment, the Global Fund agreed to fund three Solar for Health pilot sites in Angola. Subsequently, solar panel installations for the provincial warehouses of Luanda, Moxico and Cuando Cubango were completed.
- Access to affordable transport for distribution is limited for all public warehouses.

Quality assurance

- Outside the Global Fund-funded programmes, the quality assurance roles of the National Directorate for Essential Medicines and Equipment (DNME), the General Health Inspection Service (ISG), the National Quality Control Laboratory are not fully exercised;

[12] USAID-funded PSM assessment, 2017

[13] Presidential Decree no. 269/14 (September 2014)

[14] As part of the Solar for Health Initiative

- Angola does not yet have a national market authorization and drug registration system;
- The National List of Essential Medicines has not yet been validated and disseminated;
- In relation to pharmaco vigilance, a ministerial decree which decentralizes related activities has been published in 2018. However, staff need to be trained in pharmaco vigilance at provincial and municipal levels;
- The country does not have a legislation for medical devices and hospital equipment;
- Limited access to capacity development opportunities for DNME and ISG staff, reagents and transport facilities contribute to the limited scope of quality assurance interventions.

Supply management

The logistics management information system is characterized by:

- The absence of a robust internal stock management system which would link the logistics information at CECOMA, regional and provincial warehouse levels.
- Vertical reporting of consumption data per programme;
- Absence of logistics coordination systems between Programmes;
- Paper-based data collection instrument (stock cards) system in place. Stock-cards are not filled in, filled in incorrectly or analysed too late.

To address these challenges, Angola's Country Co-ordination Mechanism (CCM) allocated a portion of the country's allocation to Health Systems Strengthening (HSS), both under NFM 1 and NFM 2. In NFM 1, the HMIS and LMIS components of the RSSH grant were by a large not executed. Under NFM 2, the RSSH Funding Proposal, which took two years to reach TRP approval (November 2017-June 2019) did not secure GAC approval. As a result, **since 2016, the three disease grants have been implemented without most of the planned HMIS and LMIS interventions.** This has hampered grant performance.

During the same period, the PEPFAR/CDC-funded ICAP Project and the PEPFAR and PMI/USAID-funded GHSC-PSM Project have been working with MOH to address many of the challenges in the HMIS and LMIS systems both at national and sub-national level, with Benguela being a priority province. The PEPFAR/USAID-funded m2m Project (also present in Benguela) and, both, the GF PR in Malaria World Vision and the PMI/USAID-funded Health for All Project (present at national level and high burden malaria provinces), are also supporting the MOH in PMTCT and Malaria service delivery and systems strengthening activities respectively. PEPFAR/CDC-funded partner, AFENET, supports quality control of HIV and TB laboratories, with implementation of QC in laboratories at the various levels of care in Benguela.

Vision and Technical Assistance Approach for the Z Grant

The proposed technical assistance approaches and proven, public health interventions outlined in this section are aimed at improving service coverage with a focus on pregnant women, children under 5, adolescent girls and young women and key populations. The RSSH approach included in this proposal aims to **sustain the gains made by the Disease Programmes in the last five years, (i.e. since NFM 1) at national level while accelerating improvements with special attention to the Province of Benguela.**

Integrated Technical Assistance Approach

The technical assistance approaches in the Z grant are based on the assumption that **only a strong and integrated national health system** will allow Programmes to implement evidence-based public health interventions and achieve service targets in a sustainable way. In an environment where funding for Public Health Programmes from both Government and outside donors is diminishing, Programmes have to stop working in silos and rather coordinate partners and scarce resources to address common challenges that hinder the system's ability to perform well. Our proposal recognizes that proven public health interventions are known and that the country has enough policies and resources in place to make them operational. But what is lacking is a **strong culture of data use** within the health system so that MOH and CSO teams at national and sub national levels can make use of the data that their programmes produce to inform on prioritization and on differentiated care models that take into consideration, geographic location, gender, age and social determinants of health. What is also lacking is **a framework for problem solving**, that promotes a team approach, an **out of the box thinking**, that focuses on **how to take charge of challenges** and **steer resources** to prioritize, plan and execute on the plans. While the Z grant will address all 6 building blocks of the health system: service delivery, health workforce, health information systems, access to essential medicines, financing and leadership and governance, it will focus more intensely on the two cross cutting pillars: **health information systems and leadership, management and governance.**

Creating a Culture of Data Use

At the core of improving the health information system in Angola is creating a safe learning environment where teams gradually build their proficiency in using data. We propose to **reinvigorate routine supportive supervision** at all levels as the mechanisms to gradually improve the accuracy and reliability of programme data.

Routine supportive supervision is defined as: "**a facilitative approach to supervision that promotes continuous improvements in the quality of care by providing the necessary leadership and support for quality improvement processes and by emphasizing mentorship, joint problem solving and two-way communication between supervisors and supervisees**[15]". In a supportive supervision model[16], the following elements are essential:

1. Supervision must be approached as a mentorship and learning opportunity. It is a safe space, not a punitive space;
2. Supervision visits must be consistently done according to a plan and to ad hoc needs based on data analysis. They are not a one-off activity;
3. Ideally it is conducted by a multidisciplinary team that will consistently come back;

[15] Measure Evaluation Project. A USAID-funded Project implemented by the University of North Carolina at Chapel Hill, 2013.

[16] Adapted from: Making Supervision Supportive and Sustainable: New Approaches to Old Problems. Maximizing Access and Quality Initiative. Marquez L., Kean L., MAQ, Paper No. 4. Washington DC, USAID. 2002.

4. Performance is observed and compared against an agreed-upon standard;
5. Direct and objective feedback is given to the supervisees and vice-versa. Feedback is objective because it is supported by Programme data (or lack thereof) and by direct observation of service delivery against national guidance;
6. Two-way communication between supervisors and supervisees is established. Supervisors must be willing to listen and learn as well;
7. Actual Programme data (as opposed to abstract, generic data) is discussed using an inquiry method: inviting reflection and analysis by asking questions on the data and allowing participants time to "wrestle" with the answers;
8. A systems-thinking approach to problem solving is used where supervisees are encouraged to work in teams and think of causes and solutions within their sphere of influence;
9. Follow-up on previously noted issues is a must that should be the starting point of the next supervision visit;
10. Enforcing national guidelines, protocols and instruments to use;
11. There is always an element of technical improvement i.e., a technical update, new concept or intervention that is shared, how to calculate an indicator among others;

The goal is to stay away from a more traditional way of conducting supervision or an "inspect and control" approach which creates a culture of fear and punishment and demoralises staff, leaving little incentive for improvement, while moving towards the model of supportive supervision aiming to quality improvement and involvement of the facility staff.

Introducing Leadership, Management and Governance Practices

As teams develop an interest and proficiency in the use of the data their Programmes are producing, we must also work on improving the teams' ability to tackle challenges and steer resources by practicing strong leadership, management and governance practices. Leadership, management and governance practices in the health sector can be defined as:

- **Leadership:** Mobilizing others to envision and realize a better future[17].
- **Managing:** Planning and using resources efficiently to produce intended results[18].
- **Governance:** The process of decision-making and implementation of those decisions[19]

In this proposed technical assistance model[20], we start from the premise that leadership, management and governance practices can be learned and applied to daily work at any level of the health system. By applying the practices consistently, health managers and their teams can systematically make improvements to service delivery and ultimately health outcomes. Leading practices are not independent of management or governance practices and accomplished managers move fluidly between them to support their teams to face challenges and achieve results.

[17] Management Sciences for Health, 2010

[18] Idem.

[19] UN Economic and Social Commission for Asia and the Pacific, 2009.

[20] Adapted from the Leadership, Management and Governance Evidence Compendium. From Intuition to Evidence: Why Leadership Management and Governance Matters for Health System Strengthening. A Literature review. Amref; IPPF; John Hopkins Bloomberg School of Public Health; MEDIC Mobile; Yale Global Health Leadership Initiative; Management Sciences for Health. 2017.

Table 2: Leading, Managing and Governance Practices of UNDP's technical assistance approach in Angola

Leading Practices	Managing Practices	Governance Practices
Scanning: **Teams have up-to-date, valid data and knowledge of their beneficiaries, the health system and its context; managers also know how their own behaviours and value system affects others**	**Planning:** Teams have well-defined results and an operational plan with assigned resources.	**Cultivating accountability:** health services are provided in accordance to their design; mechanisms are included to ensure participation of beneficiaries in planning and key decision-making points.
Focusing: **Teams are driven by a well-defined mission, strategy and priorities**	**Organising:** Teams have functions, processes and procedures for efficient operations; staff are aware of their job responsibilities and expectations.	**Engaging Stakeholders:** enforcement of the rules is ensured; rewards for good performance and consequences for negative performance are available and used.
Aligning: **Teams ensure that internal and external stakeholders understand and support national goals**	**Implementing:** activities are carried out efficiently, routine data is used to inform daily decisions; plans are adjusted to changes in circumstances.	**Stewarding Resources:** resources are mobilized to reach goals.
Inspiring: **Teams display an attitude of continuous learning and they show commitment, even when setbacks occur.**	**Monitoring:** Teams continuously reflect on progress against plans, provide objective feedback, incorporate the needed improvements into existing processes.	**Setting Shared Strategic Direction:** managers have the necessary authority to achieve planned objectives.

These strategies—**a strong focus on revitalising routine supportive supervision as well as building leadership, management and governance capacity in health managers and their teams**—form the technical assistance approach that UNDP intends to provide to the MOH and in particular, the HIV, Malaria and TB Programmes through trainings, mentoring and coaching. This approach will **ensure that the following known, evidence-based public health practices are implemented, scaled-up and sustained in Angola.**

Promoting evidence-based Public Health Interventions

HIV

- **Testing Modalities:** introducing or scaling-up differentiated HIV testing services to increase HIV case finding, such as index testing, partner tracing, online outreach approaches, hot-spot based mapping among others; updating and scaling up the implementation of national HIV testing guidelines.

- **Care and Treatment:** offering differentiated care and treatment to PLHIV which have been identified, with an emphasis on linkages to care, initiating ART, patient clinical follow-up and adherence support, and increasing access to viral load testing.
- **Pregnant women:** build on the existing programmes such as m2m in Benguela to strengthen the PMTCT cascade using the normative four-pronged approach[21] and strengthening integration of services across ANC, SRH, HIV, and Malaria services.
- **AGYW and Key populations:** Apply lessons from the USAID/LINKAGES project and from ADPP using a risk assessment approach to counsel AGYW and tailor services based on epidemiology and expected positive yield; redefinition of the minimum package of services for these groups that take into consideration risk for contracting HIV; improving linkage of HIV positive AGYW and KPs to PMTCT, care and ART by incorporating linkage and care indicators into the package; expanding stigma and discrimination trainings to health facility personnel in Benguela.

Malaria

- **LLINs coverage: distribute LLINs** during routine ANC services to ensure coverage of pregnant women and children under 1 year of age[22] based on national prioritisation to ensure universal coverage; prioritisation in Benguela will be done based on available data at municipal level (given that Benguela's overall malaria burden is 10% and not considered a high burden province).
- **Testing:** improve malaria diagnostic rate (microscopy and RDTs); establish early warning systems to alert of possible outbreaks.
- support t) and,
- **Pregnant women:** Training of NGO activistas working in PMTCT and with FSWs (who are pregnant) to include IPTp messages in their daily outreach, including promotion of uptake of ANC services and delivery in a health facility; support the procurement of Fansidar to ensure availability in Benguela province.

TB

- **Case Detection:** Support increased X/MDR-TB case detection and diagnosis through making all GeneXpert machines available in the country operational, therefore expanding the number of GeneXpert sites, as well as LPA assay, liquid and solid cultures; continuous monitoring of national guidelines to use of a shorter MDR/RR-TB treatment regimen (9 months); advocacy with Government to honor its commitment of providing TB drugs to treat all new TB cases and 79% of estimated MDR/RR-TB cases in Angola by 2021.
- **One-Stop-Shop model:** In Benguela, expand and strengthen existing microscopy sites through the procurement of LED microscopes and establishment of referral and counter referral system to diagnose X/MDR-TB; and capacity enhancement of staff through a regular cascade of cost-effective training that will include HIV/TB co-infection.
- **Community DOT:** Evidence regarding the effectiveness of C-DOT interventions abound. Angola's PNDS (2018-2015) indicates that C-DOT interventions be implemented across the country. What is missing is a specific strategy to do so. The Z Grant will provide the opportunity

[21] 1) primary prevention of HIV infection among women of childbearing age; 2) prevention of unintended pregnancies among HIV-positive women; 3) prevention of HIV transmission from HIV positive mothers to the infants and 4) provision of continuous care and treatment for infected mothers, partners and their children (WHO, 2008)

[22] This is based on two assumptions: That the estimated 600,000 LLINs that were not distributed during 2018 can be recovered from provincial warehouses and that the Government of Angola fulfills its procurement commitment under the counterpart financing requirements by the end of 2020.

to design a national strategy, based on WHO guidance and lessons learned from previous Community DOT experience in Angola. The strategy will articulate roles and responsibilities within the health and community systems, targeting and monitoring approaches.

TB/HIV

- **PLHIV:** provision of IPT.
- **Co-infected TB and HIV patients:** strengthening the TB/HIV co-infection cascade, through better integration of TB and HIV services**/HIV co-infection detection:** Strengthen decentralised TB/HIV provincial level joint planning, coordination, training and monitoring through integrated supported supervision; strengthen national level coordination of HIV/TB planning and management through the revitalization of the TB Technical Working Group (TWG). Specifically, **in Benguela,** the Z grant will help strengthen TB/HIV iintegrated care by ensuring that all co-infected patients access prevention, care and treatment services through the “one-stop-shop” model previously described.

Programmatic Modules

Prevention Programs for Adolescents and youth, in and out of school

Context

In 2018, UNDP conducted an independent assessment of its AGYW programme under the HIV programme. The assessment involved key informant interviews and focus group discussions in the provinces of Benguela, Cunene and Huila[23]. As elsewhere in the region, poverty, culture and inequality were identified as the main structural drivers of AGYW vulnerability to HIV in those provinces. Limited life prospects, limited access to accurate SRH information and health services when multiple concurrent sexual relationships are socially acceptable make AGYW particularly exposed to early pregnancy, unsafe abortion, STI/HIV infection and related consequences.

Angola is part of the Global Alliance for Prevention. However, since 2016, the GF has been the only donor funding the delivery of HIV prevention services for AGYW in Angola. Two UNDP/SRs (ADPP and APDES) have contributed to the positive performance reported in the last two PUDRs in the provinces of Bie, Huíla, Luanda, Benguela, Cunene and Cuando Cubango. In the last PUDR, 60% of the AGYW were "out-of-school" as opposed to "in school girls" which responds to the TRP recommendation at the start of NFM2[24]. However, UNDP and CSO SRs jointly acknowledge that there is also a need to better define the minimum package of services for this group as well as better determine their level of risk for HIV in order to determine a differentiated model of care.

Efforts at defining the package of services for FSW, MSM, TG and AGYW as well as community support packages for PMTCT and treatment adherence were undertaken by UNDP in 2019, through a consensus-building workshop with SRs, INLS and MASFAMU, the Ministry of Social and Family Affairs.

Objective

To build on the interventions implemented since 2017 by the SRs under the current grant (ADPP and APDES) in seven provinces (Luanda, Benguela, Bié, Cunene, Cuando Cubango, Namibe and Huila) by reaching out adolescents and young girls in and out of school with a defined package of services while introducing a risk assessment tool to better understand AGYW risk profile.

Priority interventions

Advocacy and package definition

- Building on the experience gained through the Global Alliance for Prevention, create a Technical Working Group (TWG) with the Ministry of Education, Ministry of Family and Women (MINFAMU), Ministry of the Interior, MOH, NGOs and other health partners to discuss the high HIV prevalence data found among young women through the DHS, MIS and KP surveys and the LEA assessment recommendations and identify key interventions that could be applied across sectors to address the underlying causes and gender dynamics such as: the role of women in society; socially acceptable polygamy (especially in rural contexts); sexual and reproductive health curricula in schools; promotion of delaying pregnancy; condom negotiation among others;
- Refine the minimum package service definition for this group and align data collection

[23] Assessment of UNFPA adolescent girls and young women (AGYW component of the UNDP project: strengthening the national response to HIV/aids in Angola, UNDP, September 2018

[24] See TRP Applicant Response Form, Angola TB/HIV Funding Request, Issue 2, page 4, November 2017

instruments;
- As part of the minimum package revision, discuss the provision of legal protections in cases of sexual exploitation and violence, and adolescents' referral to appropriate child protection services;
- Support CSOs and other partners to promote empowerment, sexual and reproductive rights of adolescent and young girls out of school;

Supply of health products
- Procurement, supply management, quality assurance of HIV tests, reagents and laboratory consumables in accordance with national HIV testing strategy
- In Benguela, ensuring continuous supply of HIV tests
- Promotion of the use of male and female condoms, which will be procured by Government

Population mapping and targeting
- Adapt the statistically validated 17-question risk assessment questionnaire used with KPs in Angola to this group and test it (SSR ADPP has initiated the use of the tool in its AGYW component).
- Conduct hot spot mapping for AGYW in Benguela;

Outreach

- Based on the agreements with the TWG, produce and broadcast targeted radio and TV messages;
- Use of innovative social media e.g. SMS messaging, smartphone apps such as Oi Meninas[25] e.g. WhatsApp, Facebook, Instagram etc. to sensitize young people/adolescent on the prevention of HIV/STIs and unwanted pregnancy;
- Conduct awareness campaigns and sensitization targeting adolescents and young girls out of school;
- Support to peer and community support groups including sports activities and skills training;

Community-facility linkages

- Training of health and outreach workers in the provision of teenage and youth friendly services;
- Targeted counseling and testing services for vulnerable adolescents and young girls and linkage to the continuum of care, including PMTCT and access to ART

Target areas and populations

In and out of school AGYW in Luanda, Benguela, Bié, Cunene, Cuando Cubango, Namibe and Huila which are the provinces in which AGYW interventions have been implemented since 2017. Given the GF's selection of provinces for the sub-national approach under NFM 3, the Z grant will be used to prepare AGYW, Activistas and SSRs operating in Luanda, Cunene, Namibe and Huila for the end of GF support.

[25] Funded by the Global Fund under NFM 1; currently not operational due to lack of funding

Preventing Vertical HIV Transmission

Context

Angola's population is projected to reach 30,175,553 in 2019[26] with nearly two-thirds (64 per cent) below the age of 24 years and a growth rate of 3.7%. At this rate, Angola's population will double in twenty years. Fertility rates have slightly reduced from 7.2% in 2001 to 6.2% in 2016. However, adolescent fertility rate is among the highest in the region, with 163 births per 1,000 adolescent girls aged 15-19, 239 per 1,000 in rural areas. Coverage of family planning usage is at 14%, up from 6.6.% in 2001, while unmet need for family planning among adolescent girls aged 15 to 19 is 43%.

Estimated at 26%, HIV mother to child transmission rate in Angola is characterised as one of the highest in the world[27] Although there have been improvements in the last few years, many pregnant women do not attend ANC and more than 50% of the labours occur outside health facilities. More than 40% of pregnant women in ANC are not tested for HIV. Less than 50% of exposed children had access infant prophylaxis and of those who had access to treatment, only 10% had EID.

In 2017, it was estimated that only 36.3% of HIV positive pregnant women received ART. By the end of 2019 however, the coverage for this indicator had increased to 64.8% in great part due to the focus of the National AIDS Programme (INLS) on the ongoing campaign "Born Free to Shine".

Led by Angola's First Lady, this PMTCT campaign is based on the National Plan for the Elimination of Mother-to-Child Transmission of HIV 2019-2022, developed with UNDP/GF support, as a response to the 2017 TRP recommendation to the CCM. The Born to Shine campaign involves provincial PMTCT targets and mobilises wives of provincial governors to promote their achievement. This initiative also resulted in significant opportunities for the INLS to mobilise additional Government financial resources in order to ensure availability of HIV tests and ARV. The campaign also led to the offer of PMTCT-related health equipment such as the leasing of the Viral Load (VL) platform in Benguela by the private sector.

The Program's new integrated data collection tools[28] enable the collection of data on newly infected HIV positive pregnant women and women who were in ART before becoming pregnant. The community component of the HIV grant supports the provision of community support to PMTCT and treatment services in 50 selected Municipalities in 6 provinces (Luanda, Namibe, Huíla, Cuando Cubango, Cunene and Bié).

Remaining challenges to PMTCT include low ANC attendance (68.5% for at least one ANC visit); low rate of institutional delivery (40%); a high rate of loss of follow-up of women living with HIV and their babies after childbirth; only 50% of ANC sites offering PMTCT services; insufficient institutional integration between HIV and SRH; limited coverage of primary HIV prevention interventions targeted at AGYW and youth; and limited access to early infant diagnosis (EID). These challenges are described at length in the National Plan for the Elimination of mother-to-child transmission of HIV, syphilis and hepatitis B (2019-2022).

[26] Projeção da População 2014-2050, Instituo Nacional das Estatisticas, INE

[27] Spectrum projections, INLS, 2018.

[28] These have now been introduced and are being implemented in 11 of 18 provinces (Luanda, Benguela, Cunene, Huíla, Cuanza Sul, Huambo, Bié, Bengo, Cabinda, Lunda Sul and Moxico.

Objective

To strengthen service integration with other Programmes and community promotion of ANC visits and institutional deliveries.

Priority Interventions

Policy and advocacy

- Dissemination of the 2019-2022 National Plan for the Elimination of mother-to-child transmission of HIV, syphilis and Hepatitis B.
- In Benguela, convene Sobas and traditional birth attendants in rural communities and developing counselling and incentive mechanisms to encourage referrals for ANC and institutional deliveries;
- In Benguela, support the Provincial and municipal health office teams to convene regular coordination meetings among PEPFAR and other partners working in the area (i.e., m2m, ICAP among others).
- In Benguela, coordinate resources and scope closely with PEPFAR partners already on the ground, especially with m2m on PMTCT and on PSM issues with the PSM Project

Supply of health products

- Procurement, supply management, quality assurance of HIV tests, ARVs, reagents for EID, other reagents and laboratory consumables in accordance with national HIV testing strategy, the latest ARV treatment protocol and the VL Expansion Plan. Benguela will process samples from 7 provinces.
- In Benguela, ensuring that Born to Shine campaign targets are met through the continuous supply of PMTCT health products

Service delivery

- Intensifying the integration of Family planning counselling services including male and female condom distribution, among all HIV positive women attending SRH services;
- Promoting differentiated HIV testing services (HTS) including HTS for all PLHIV, including pregnant women attending ANC and SRH services; index testing for all PLHIV already enrolled in the HIV service, with partners and children tested first.
- Provision of differentiated ART (Option B+), improving treatment monitoring and continuous adherence assessment, counselling and support;
- Testing during labour, delivery and postnatal period for those missing testing at ANC and re-testing of pregnant women who tested negative to HIV during ANC;
- Mother/ baby pair follow up will also be prioritized and a mechanism aimed at monitoring retention in care for pregnant women on Option B+ for PMTCT and ARV prophylaxis for HIV exposed babies, will be institutionalised;
- Strengthening the follow up of HIV exposed infants and EID, through the community-facility linkages facilitated by NGO SRs, psycho-social support, involvement of HIV positive mothers and collaboration with Mothers2Mothers in the case of Benguela.

Capacity development

- In Benguela, pilot the drug prescription and dispensation system for ARVs developed by the INLS, in at least 6 of the health facilities that concentrate the biggest numbers of PLHIV on treatment. The system makes it possible to obtain epidemiological data and monitor the collection of drugs. As such, it helps the collection of more reliable data on the number of people being treated, the therapeutic regimens used and the loss to follow-up. The

implementation will be informed by the lessons learned during the pilot implementation in Hospital Esperança in Luanda.

- Training of health workers in Early childhood diagnosis (DPI) in Benguela and one additional province
- In Benguela, data quality audits will be performed for malaria, HIV and TB indicators at select facilities and CSOs to estimate the true value of double counting.

Target areas and populations

All pregnant and breastfeeding HIV infected women attending ANC, labour wards and postnatal care; and HIV exposed infants, also focusing on key and vulnerable populations (FSWs and AGTW who are pregnant) in Benguela province as well as priority provinces for the Nasser Livre para Brilhar campaign i.e. Benguela, Cuanza Sul, Cunene, Huambo, Huíla, Luanda, Lunda Sul e Moxico.

Community support to PMTCT will be implemented in the provinces of Luanda, Benguela, Bié, Cunene, Cuando Cubango, Namibe and Huila which are the provinces in which such interventions have been implemented since 2017. Given the GF's selection of provinces for the sub-national approach under NFM 3, the Z grant will be used to prepare pregnant women, Activistas and SSRs operating in Luanda, Cunene, Namibe and Huila for the end of GF support.

Treatment, Care and Support, Treatment Adherence, Treatment Monitoring

Context

The antiretrovirals treatment (ART) coverage in people living with HIV (PLHIV) was estimated to be 24% in 2017[29]. By the end of 2019, this rate had not significantly changed, with 26.4% of PLHIV reported on ART (91,164 out of 345,248 PLHIV), estimated after applying the adjustment factor agreed with UNAIDS[30]. In relation the treatment adherence, according to the DQA conducted by UNDP in 2018, "for patients that initiated treatment in 2015 and 2016, the retention rate at 12 months was 42.6% in the nine Service Delivery Points assessed. For the 24 months retention, for patients that initiated treatment in 2015 the retention was 52.8%"[31]. Therefore, Angola is a context with extremely low treatment coverage and low treatment adherence also.

Since 2016, the Government of Angola has stepped up its efforts to fund the procurement of ARVs, despite an adverse macroeconomic context. In line with GF counterpart financing requirements, Government funding has steadily moved from 40% in 2016 to 70-80% of funding available for ARVs in 2019. As such it is gradually replacing GF funding. Alignment with national treatment protocols remains an issue, with a variety of regimens being used by practitioners. Absence of a unique patient identifier code results in complex needs quantification exercises. In March 2020, the country officially shared its Transition Plan towards TLD.

Community support to treatment adherence remains largely insufficient. The GF is the only donor supporting this component with three UNDP SRs (ODP ADPP, APDES) and one SSR (ASCAM) delivering treatment adherence and retention services in 6 provinces (Luanda, Benguela, Cunene, Namibe, Cuando Cubango, Huila). In 2016, among PLHIV who are receiving ART and

[29] UNAIDS data 2020 (http://aidsinfo.unaids.org/).
[30] HIV PUDR, Jul-Dec, 2019.
[31] Assessment of M&E and Data Quality in Angola, Cohort 2017, UNDP, 2018

had a viral load test, only 67% were virally suppressed[32]. In 2019, only 26% of PLHIV on ART had access to VL measurement services (INLS, Spectrum data).

In relation to data collection and quality improvement, three HIV regional supervisors, funded by HIV grant have been hired, trained and seconded to INLS to support programme supervision and data collection in 14 provinces[33].

Objective

To promote better coordination and task allocation within ART sites, sensitisation and training of staff on the revised HIV diagnosis and treatment guidelines and improved community follow up of patients to reduce loss to follow up (LTFU).

Priority interventions

Supply of health products

- Procurement, supply management, quality assurance of HIV tests, ARVs, other reagents and laboratory consumables in accordance with national HIV testing strategy and the latest treatment guidelines (March 2020).
- Procurement, supply management, quality assurance of VL reagents to be used in Benguela to process samples from 7 provinces in total i.e. Benguela, Kwanza Sul, Huambo, Huila, Namibe, Cunene and Bié as per the VL Expansion Plan.
- In Benguela, ensuring continuous supply of HIV tests, ARVs and reagents for VL services, using the new VL platform

Capacity development

- Trainings and roll-out of the use of new HIV testing and treatment protocols in 7 targeted provinces i.e. Benguela, Cuanza Sul, Cunene, Huambo, Huíla, Luanda, Lunda Sul and Moxico. Selection of province is based on National PMTCT Plan. The new testing algorithm is under development
- The new HIV testing algorithm will be included in the training package and its cost implications will be considered during the current quantification exercise. However additional resources will need to be mobilised to cover the extra costs.
- Training of health workers (Provincial health authority and health facility staff) in Early childhood diagnosis (EID) and VL. Initial training for Luanda, Benguela, Cabinda was completed in 2019 and sample collection has started. Training for Kwanza Sul, Huambo and Bié were completed in 2020. Training for the following provinces was delayed due to the COVID-19 pandemic: Huila/Namibe, Cunene, Moxico, Lunda Sul, Luanda, Cuando Cubango
- Following training sessions, supervision of EID and VL installation and expansion to other health facilities
- Capacity development support to SRs involved in treatment adherence support, including associations of PLHIV, to harmonise approached and ensure better treatment outcomes

Service delivery

- Ensuring the provision of high quality of care to all PLHIV enrolled in the HIV service, which, in Angola's context implies guaranteeing access to the basic minimum package of HIV clinical services i.e. : routine clinical assessment during scheduled clinic visits, TB screening services for PLHIV; scheduled immunological assessment; and prevention of opportunistic infections;

[32] Angola HIV/TB Funding Request, 2017

[33] The following provinces are currently not covered: Cuando Cubango, Huila, Namibe and Cunene.

- Implementation of differentiated service delivery in Benguela province [34] for PLHIV namely: i) people presenting when well, ii) people with advanced disease, iii) stable individuals, and iv) unstable individuals; and organizing the care frame work namely: (i) the types of services delivered; (ii) the location of service delivery; (iii) the provider of services; and (iv) the frequency of services, within the Angolan context;
- Scaling up viral load monitoring[35] currently done in Luanda to other provinces, through the Benguela VL platform, improving quality of clinical assessment.
- Patient follow-up and treatment adherence support through strengthening peer and community support groups, including monitoring of the care and treatment cascade metrics

Improving data quality

- Conducting a data quality audit in Benguela to quantify the true magnitude of patient double counting, retention and loss to follow-up.
- Reproduction of the new data collection instruments (integrated SRH, TB[36] and HIV) to cover a combination of the following provinces : provinces which report a high number of PLHIV (Luanda, Benguela, Huambo, Huila, Cunene), provinces which are under resourced (Moxico, Cunene, Lunda Sul and Lunda Norte); and priority provinces for the Nascer Livre para Brilhar campaign (Benguela, Kwanza Sul, Cunene, Huambo, Huíla, Luanda, Lunda Sul and Moxico).
- Training and technical assistance to implant the use of the new data collection tools (integrated SRH, TB and HIV) in the targeted provinces.

Target areas and populations

Adults and children living with HIV, including pregnant women, AGYW, KP and TB/HIV co-infected individuals in 18 provinces. Community support to treatment adherence will be implemented in the provinces of Luanda, Benguela, Bié, Cunene, Cuando Cubango, Namibe and Huila which are the provinces in which such interventions have been implemented since 2017. Given the GF's selection of provinces for the sub-national approach under NFM 3, the Z grant will be used to prepare PLHIV, Activistas and SSRs operating in Luanda, Cunene, Namibe and Huila for the end of GF support.

Comprehensive Prevention Programs for Key Populations – FSW, MSM and TG

Context

Since October 2019, the Global Fund is the only source of funding for Key Populations programming in Angola[37]. The USAID-funded LINKAGES Angola project was implemented in Luanda from January 2015 to September 2019 and in Bié province for FSWs between May and September 2018 by UNDP through the SR Management Sciences for Health (MSH), in partnership with 11 local CSOs and 5 KP grassroots groups. In Benguela province, parts of the LINKAGES care model were also implemented from 2017 to 2019 by UNDP SSR OIC. With the

[34] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach, 2016 (pg 239-242)

[35] Viral load scale up plan Angola, INLS/CDC (2017)

[36] TB Tools are now approved

[37] Small donors such as OSISA, the Frida Kahlo Foundation and The Other Foundation support discreet community activities in Luanda

change in strategy of the PEPFAR programme, LINKAGES was closed in Angola in September 2019.

Since 2017, the Global Fund has been supporting FSW and MSM-focused interventions in Luanda and Benguela province which are implemented by MSH and INLS in collaboration with SSRs ASCAM (Luanda) and OIC (Benguela). In 2018, UNDP expanded the KP programming to Biê province through APDES.

In the second semester of 2019, SR in Bié (APDES), Luanda (MSH) and Benguela (INLS/OIC) achieved significant progress. For FSW, 120% of the service target was reached (16.9% over 8%) and 8% over 3% for MSM. Despite this success, UNDP as implementer acknowledges that there is a need to harmonize the definition of the minimum package of HIV prevention services to be delivered to KP as well as the way in which SRs count and report on the KP indicators.

The package currently includes: distribution of scented condoms and lubricants (procured by USAID and GoA); the use of a risk assessment approach during counselling; hot spot-based counselling and testing for HIV and STI syndromic assessments. Treatment for chlamydia and gonorrhea is permitted syndromically for MSM and Transgender and presumptively for FSWs, as per WHO 2016 recommendations.

Objective

To build on the interventions implemented by MSH/ASCAM/IRIS in Luanda, OIC in Benguela and APDES in Bié to revise the definition of the minimum package of services, improve case finding and linkage to ART for FSWs and their clients, MSM and TG

Priority Interventions

Policy and advocacy

- Facilitate the review and validation of the draft 2018 KP policy documents i.e. the KP Situation Analysis; the Guidelines for Health Professionals attending KP; and the National KP Strategy
- Review and redefine with the INLS and KP partners the minimum package of services, following WHO guidelines, and ensuring that it follows a comprehensive continuum of prevention, care and treatment services, including building and monitoring the HIV Prevention, Care, and treatment (KP-HIVCoPCT) cascade metrics, which counts individuals and not just services[38].
- Promote the updating of national HIV counseling and testing guidelines so as to incorporate index and partner testing;

Supply of health products

- Procurement of HIV tests, supply management and quality assurance of HIV tests, as well as reagents and laboratory consumables
- Distribution of GoA and USAID-procured scented male condoms and lubricants to entice their use;
- For Benguela, procurement of Cefixime in 400 mg to be distributed with Azithromycin 1 gr (currently already in the country) among symptomatic MSM and presumptively among FSWs as part of the STI prevention aspect of the minimum package of services;
- Ensure the continuous supply of health products in Benguela province.

[38] HIV Cascade framework for key population, 2015 (USAID/PEPFAR/Linkages/fhi360)

Protection of human rights; addressing stigma and discrimination

- Implementing FSW, MSM and TG empowerment approaches as part of the programme strategy on rights education, gender-based violence (GBV)
- In Benguela, sensitization and training of health workers in the delivery of KP friendly services without stigma and discrimination;
- Dissemination of the "Know Your Rights" booklet for KPs produced in 2019 with GF/USAID support;
- Documenting violence and human rights abuses as well as advocacy to reduce stigma and discrimination on grounds of sex work, sexual identity or HIV status;
- Provide legal protections in cases of sexual exploitation and violence (for underage women engaging in sex work);
- Pursue the stigma training programme initiated under NFM 1 with the police and health professionals, ensuring INLS involvement

Outreach

- Ensure adoption of risk-assessment questionnaire to ensure that care can be differentiated by risk profile;
- Training and refresher training for Peer educators
- Sensitisation meetings and workshops for on risk reduction, VCT, treatment support, condom and lubricant use, and empowerment
- Delivery of mobile HIV testing services (HIV testing campaign in hot spots using a mobile clinic, with a team of 5 individuals (SR staff, HIV testing technician and driver)
- Transfer of MSM and Trans women-specific outreach practices to the OIC team in Benguela to increase HIV case finding (i.e., off and online outreach, index testing, partner tracing; gender identity/sexual orientation workshops);
- Transfer of hot spot and social networking mapping skills to the OIC team in Benguela using ArcGIS software and coupon/peer mobilizer strategy;

Access to treatment and treatment adherence support

- Referral and accompaniment of SWs and MSMs who test positive to antiretroviral treatment sites
- In Benguela, expansion of STI screening and treatment of chlamydia and gonorrhea syndromic for MSM and presumptively for FSWs;
- In Benguela, TB screening in the community and referrals to one-stop-shop model as well;
- Psycho-social and ART/ TB treatment adherence support to SWs and MSMs who are on ART and/or TB treatment;

Capacity development

- Orientation of SRs and SSRs on the minimum package, how to monitor and how to report.
- Training and INLS certification of NGOs on evidence-based, differentiated outreach models to improve HIV case finding such as peer to peer education, off and online; hot spot ARcGIS mapping; partner tracing among others.
- Training and INLS certification of NGOs on evidence-based ART linkage and adherence proven strategies Training and refresher training for FSW, MSM, TG on the minimum package
- Organizational capacity support to FSW, MSM and TG groups for sustainability post GF funding

Target areas and populations

All women who fit WHO definition of sex workers, MSM and TG with special focus in the provinces where SR and SSR partners are already working i.e. Luanda, Benguela and Biê provinces. Taking into consideration the GF selection of provinces for NFM 3, the Z Grant will be used to prepare the FSW, MSM, TG, Peer educators and CSOs in Luanda for the end of the GF support.

Malaria Vector Control – IEC/BCC

Context

Various factors have contributed to the recent malaria epidemic outbreaks and upward epidemiological trends in Angola. These include increased rainfall, due to climate change, as well as worsening sanitation situation in both urban and rural areas. These factors have resulted in an increase in mosquito population density. More critically, due to lack of domestic funding, the country has been unable to achieve its targeted coverage of vector control interventions neither with LLINs n IRS. A three-year rolling distribution campaign resulted only in 31% of households having at least one LLIN as of 2015 (IIMS, 2015/16). From 2014-2017, only 30% of the available LLINs were distributed during routine activities. Only 11.3 % of the population is adequately covered. IRS activities stopped in 2015.

Within Angola's integrated vector control strategy (NMSP 2016 – 2020), LLINs are the main vector control intervention. The two approaches for LLIN distributions are through a three-year rolling mass distribution campaign (2016-2018) and routine distribution at ANC and EPI to maintain coverage levels among pregnant women and children under one year of age.

In 2016-2017, seven provinces benefited from mass distribution campaigns aimed at reaching universal coverage. In 2016, a total of 2,112,987 LLINs were distributed in three provinces i.e. Benguela (1,089,431), Huila (1,023,556) and Huambo (406,030 to complete 2015 distribution). In 2017, a total of 2,442,370 LLINs were distributed in five additional provinces (Malange, Kwanza-Norte, Kwanza-Sul, Uige and Zaire).

Despite the availability of LLINs, albeit limited, uptake is also low. 22 % of children and 23 % of pregnant women slept under an LLIN the night before the IIMS survey. However, coverage improved if analyzed based on the number of household possessing at least one LLIN (61% for children and 68% for pregnant women). Therefore, significant social and behavior change communication (SBCC) efforts, before, during and after distribution, are still needed to ensure net uptake and usage of LLIN at a community level.

To address community demand issues, the malaria portfolio of ADECOS has been strengthened since 2016. Introduced in 2014 by the Ministry of Territorial Administration, in collaboration with the Ministry of Health, ADECOS are community development and health agents who are hired and paid by Government-run Fundo de Apoio Social (FAS). In relation to malaria, ADECOS have been instrumental in operationalising proven strategies such as the integrated Community Case Management (iCCM) of childhood illnesses in Angola. Training and supervision of ADECOS is supported by both the U.S. President's Malaria Initiative (PMI) through its partner PSI in 7 provinces of the north of Angola and by the GF through World Vision as PR in 6 provinces to the east of the country.[39] Lessons learned from ADECOS and resources such as behaviour-change

[39] They are Lunda Norte, Moxico, Bengo, Uige, Luanda and Malange. NFM 2 Revised Concept Note for Malaria, August 2017.

messages and materials, from these partners will be useful for replication in Benguela province, especially in rural areas.

Objective

To distribute LLINs during routine ANC services to ensure coverage of pregnant women and children under 1 year of age[40] based on national prioritisation; prioritisation of Benguela will be done based on available data at municipal level (given that Benguela's overall malaria burden is 10% and that the province is not classified a high burden province).

Priority Interventions

Policy and advocacy

- In coordination with international partners (PMI-funded partners working at warehouses) mobilise resources to recover LLINs that were not distributed in 2019, (approximately 600,000) and that are left in certain provincial warehouses, for routine distribution.
- Follow-up with partners to create a coordination forum which will engage with the Ministry on PSM issues to ensure alignment of efforts nationwide;
- In coordination with GHSC-PSM Partner, support the strengthening of the OpenLMIS system already installed at the Provincial warehouse in Benguela and the warehouse (deposito) at the Provincial hospital to improve on the stock control system.
- In Benguela, convene Sobas and traditional birth attendants in rural communities and develop counselling and incentive mechanisms to encourage referrals to ANC and institutional deliveries

Supply of health products

- Procurement, supply management and quality assurance of health products including Rapid Diagnostic Tests, ACT, Artesunate, Fansidar as well as reagents and laboratory consumables
- Distribution of LLINs already in stock
- Ensure the continuous supply of malaria health products in Benguela province.

Service delivery

- Improve differential febrile diagnosis particularly for vulnerable populations by strengthening and expanding access to diagnosis of all fevers at all levels of the health system, predominately by scaling up the use of malaria RDTs in public health facilities.
- Establish early warning systems to alert of possible outbreaks;
- Reprint IEC materials to promote the correct use of LLINs before, during and after the mass campaign and/or routine distribution. The mass campaign is conditional on whether the GoA successfully procures LLINs during the second semester of 2020, as planned. Routine distributions are contingent on the success of recovering LLINs mentioned previously.

Capacity development

- Training of NGO activistas working in PMTCT and with FSWs (who are pregnant) to include IPTp messages in their daily outreach, including promotion of uptake of ANC services and delivery in a health facility

[40] This is based on two assumptions: That the estimated 600,000 LLINs that were not distributed during 2018 can be recovered from provincial warehouses and that the Government of Angola fulfills its procurement commitment at the end of 2020.

Target areas and populations

All with fever symptoms, and especially vulnerable populations such as pregnant women and children under 5, with a special focus on Benguela province.

Malaria - Intermittent Preventive Treatment (IPT) – In Pregnancy

Context

In a country where 36.6 % of the population live below the poverty line (World Bank, 2018), malaria is indeed a so called "poverty" disease. Malaria parasite prevalence in under 5 years old in the richest quintile was 2% against 21% in the poorest quintile of the population (IIMS, 2015-2016).

Women's socio-economic situation exposes them further to the health consequences of poverty, hence malaria. When disaggregated by gender, the national literacy rate of 65.6% drops to 53% for women, against 80% for men. Yet, mother's level education is a key determinant for malaria prevalence in children. Children of mothers who had received secondary school or higher education only had 5% parasite prevalence against 23% for those whom the mothers had a lower schooling level.

Geographic disparity is also to be added to gender disparity. Prevalence of malaria in children under five years of age living in rural areas is 21.8% against 7.5% in urban areas. Yet, pregnant women's access to antenatal care in rural areas (63%) continue to be significantly lower than in urban areas (92%), for any pregnancy during the past 5 years.

In such a contrasted context, only 37% of the pregnant woman received any dose of SP during their last pregnancy. The rate drops further to 19% for those who had received three or more doses at ANC as per WHO recommendations. The rate is also lower for women living in poorer rural areas (39%) compared to 74% for those living in urban areas. It is equally lower (13%) for women without any formal education compared to 26% for women with secondary or higher education.

Therefore, uptake of IPTp in Angola is socio-economic dependent. In 2016, 3% and 2% of the reported malaria cases and deaths were pregnant women. Increasing both ANC attendance and IPTp coverage is a top priority for the NMCP with the objective of improving health outcomes for the pregnant women and her unborn child. However, over the past 3 years, key preventative services such as IPTp for pregnant women continue to report low performance. Out of 501,390 pregnant women who received Antenatal care (ANC) during the second semester of 2019, only 118,683 received the 3rd dose of IPTp. This corresponds to 23.67% of the pregnant women who received ANC services[41], which is lower than the rate of 37% reported in the last IMMS.[42]

Objective

To increase low coverage of IPTp during routine ANC and iCCM services

Priority Interventions

Policy and advocacy

- In Benguela, convene Sobas and traditional birth attendants in rural communities and develop counselling and incentive mechanisms to encourage referrals for ANC and institutional deliveries;

[41] Malaria PUDR, Jul-Dec, 2019.

[42] All figures from this section (Context) were taken from the 2015-2016 IMMS, except when referenced otherwise.

Supply of health products

- Procurement and delivery of Fansidar to cover the expected number of pregnant women in Benguela province

Service delivery

- Dispensing and follow-up with mothers to ensure they take 3 doses will be reinforced during the intensified municipal to health facility supervisions and on the job trainings as well as during engagement with Sobas, trainings of Activistas and traditional birth attendants.

Capacity development

- Training of NGO activistas working in PMTCT and with FSWs (who are pregnant) to include IPTp messages in their daily outreach, including promotion of uptake of ANC services and delivery in a health facility

Target areas and populations

All pregnant women, with a special focus on Benguela province.

Malaria Case Management – Facility-based treatment

Context

Over the past 3 years, while there has been a notable decrease in malaria deaths as a result of improvements in malaria case management, the trend in malaria cases shows no significant changes at national level. From 2017 to 2020, the NMCP projects an increase from 10.5 million to 14.4 million of suspected malaria cases annually.

Only 30% of all public health facilities have functioning laboratories. This leaves 70% of all public health facilities diagnosing malaria using RDTs. In 2016, 7,649,902 suspected malaria cases were reported through the HMIS, of which 93,7% were tested either by microscopy or RDTs. Those not tested were either due to stock outs of RDTs in the lower level health facilities, or practitioner preference for clinical diagnosis. The 13.9 million smears RDT needed over the 2017-2020 period are to be funded by the Government of Angola, in an adverse macro-economic context. Since 2016, the USAID PMI and the Global Fund have also contributed funding for RDTs, either in six high transmission Provinces (PMI) or nationally (GF).

The national malaria treatment protocol prescribes Artemisinin and amodiaquine for treatment of confirmed malaria cases in the community; Artemether lumefantrine (AL) for treatment of confirmed malaria at public health facilities; and dihydroartemisinin piperaquine (DHQ) as an alternative artemisinin drug. Drug efficacy studies carried out in 2015 showed between 87% to 97% efficacy for AL and 100% for DHQ (NMSP 2016 – 2020).

Aaccess to malaria treatment is hampered by the country's health system challenges, the greatest of which is the number, capacity and geographical distribution of human resources. In 2016, there were 8 health professionals (all categories) per 10,000 inhabitants, with a hugely asymmetric distribution between urban and rural areas[43]. 85% of medical doctors were located in Luanda and 25% in 17 out of 18 provincial capitals. Technical capacity of existing human resources is also insufficient and needs reinforcing through training and mentoring. Insufficient funding and capacities in procurement and supply management at decentralised levels result in frequent stock outs of ACTs and rapid diagnostic tests RDTs. Lack of these needed commodities at health facility

[43] PNDS 2012 - 2017

or community level discourages treatment seeking behaviour or treatment adherence and further contributes to increased morbidity and mortality.

There is also an urgent need to expand the coverage of SBCC interventions in order to promote treatment seeking behaviour, acceptance of malaria diagnosis and effective completion of treatment according to the national guidelines.

Objective

To increase treatment of all suspected cases at public health facilities and through the expansion of iCCM services in Benguela province.

Priority Interventions

Policy and advocacy

- With the involvement of Sobas and other NGO activists, promote treatment seeking and treatment adherence through consistent and interpersonal BCC during health facility and iCCM visits. Messaging will aim to improve care seeking behaviour and families' competencies with regards to treatment compliance and malaria prevention.

Supply of health products

- Procurement, supply management and quality assurance of RDTs, ACT, reagents and other consumables for laboratories.

Service delivery

- Improve differential febrile diagnosis particularly for vulnerable populations by strengthening and expanding access of diagnosis of all fevers at all levels of the health system predominately by scaling up the use of malaria RDTs in public health facilities
- *Capacity development*
- Ensure compliance with national treatment guidelines and rational use of first line treatment with ACTs;
- Where possible, microscopy will be continued in facilities (mostly hospitals) with functional laboratories (functional microscopes, supplies and materials) including improvements in quality in Benguela, in coordination with PEPFAR/PMI-funded projects working on laboratory improvement;

Target areas and populations

All suspected cases with a particular focus on vulnerable populations such as pregnant women and children under 5 and on Benguela province

TB Case Detection and Diagnosis, TB Treatment

Context

In Angola, the TB programme has made relative progress since 2013. In 2016, the case notification rate (CNR) was 222/100,000; the treatment success rate (TSR) was 69.7%, (up from 61% in 2013) and the treatment coverage (TC) was 60% for new and relapse TB cases. In 2015, the notification rate (NR) for RR/MDRTB was 8.4% (227), the treatment success rate (TSR) for RR/MMDRTB was 74% (2013 cohort), and the number of RR/MDR TB cases which started second line treatment in 2016 was 231 (8.6%).

These improving results were achieved thanks to the expansion of the TB service network during the period from 111 to 133 Diagnostic and Treatment Units and from 41 to 147 Treatment Units from 2013 to 2016. There has also been an expansion of the sputum smear laboratory network from 121 to 155 laboratories by 2016, and an expansion of the laboratory diagnostic network for MDR-TB with 15 GeneXpert installed by 2016. 13 Sanatorium Hospitals and 9 Dispensaries (DATS) complete the TB service delivery network.

These improving results were achieved thanks to the expansion of the TB service network during the 2013 – 2016 period from 111 to 133 (as of December 2018) Diagnostic and Treatment Units and from 41 to 147 (also as of December 2018) Treatment Units from 2013 to 2016. There has also been an expansion of the sputum smear laboratory network from 121 to 167 laboratories by 2019, and an expansion of the laboratory diagnostic network for MDR-TB with 29 GeneXpert installed by May 2020. 13 Sanatorium Hospitals and 9 Dispensaries (DATS) complete the TB service delivery network.

However, effective TB control is limited by poor case detection quality and reliance on low sensitive tools such as microscopy. Bacteriological confirmation is still inadequate with poor diagnostic infrastructure, and shortage of health staff. To address these issues, national policy and guidelines have already been updated and now focus on bacteriological confirmation and the expansion of GeneXpert testing. However, and despite the existence of a GeneXpert Expansion Plan, the 25 GeneXpert machines procured in 2018 with GF resources and already in country since April 2019, have not yet been set-up.

In 2019, coupled with Ministerial decree on the decentralization of TB services, the acquisition and distribution of Led Microscopes and respective reagents contributed to the detection of greater numbers of cases. 67,6% of the estimated cases of TB for the second semester of 2019 were diagnosed, corresponding to 36,663 or 34% of expected new TB cases for the year as per WHO estimates[44]. In the second half of 2019, the 24 GeneXperts in operation in 14 provinces, allowed for 705 MDR cases to be detected and reported, corresponding to 64.9% of the estimated number for the period, according to WHO. Of these, the Programme reported that 100% of the cases received treatment with the second line of drugs procured under NFM2[45].

As part of counterpart financing requirements, the Government of Angola is due to provide TB drugs to treat all new TB cases and 79% of estimated MDR/RR-TB cases in Angola by 2021.

Objective

1. To increase TB case notification rate in all forms and to make operational the DHIS2 TB module.
2. To increase treatment coverage and treatment success rate

Priority interventions

Policy and Advocacy

- Revitalize the Technical Working Group (TWG) to review national policy and guidelines, trainings programs and job aids in TB. The TWG will have the participation of the HIV Programme as well. There are no costs associated with this activity
- Organize technical working meetings (2 in the year) between sub national supervisors and laboratory personnel from 50 health facilities with GeneXpert and LPAs to reinforce the use of the diagnostic machines, and set-up the system of referral and count referral (only Luanda and Huambo have LPA machines). The second meeting will be used to assess progress

[44] TB PUDR, Jul-Dec, 2019.

[45] Idem.

against what was planned and indicators (i.e., increased in M/XDR diagnostics and referrals for treatment).

Supply of health products

- Procurement, supply management and quality assurance of anti-tuberculosis medicines, including Isoniazid, reagents and other laboratory consumables, continuous supply of quality assured first line TB drugs for paediatric treatment only) and second line TB drugs for adults, in line with national treatment protocol
- As part of counterpart financing requirements increased investments by Government of Angola to ensure continuous supply of quality assured first line TB drugs, including new paediatric formulations, and cover more MDR TB targets, in light of the reduction in Global Fund investment in MDR TB targets (500 Vs 1,000 MDR TB cases) compared to previous grant.
- For Benguela province: procurement of equipment necessary to scale-up BK tests from 18 health facilities to 50 in the province;
- For Benguela province: expansion of the TB laboratory diagnosis network with acquisition of 33 iLED microscopes and immunofluorescence kits to ensure smear microscopy in Benguela's municipalities;
- For Benguela province: procurement and set-up of 1 LPA and Bactec systems;

Service delivery

- Scale up IPT for all eligible PLHIV and TB exposed children under five years old;
- Screening for TB among PLHIV at every visit « using the standard WHO-4 question criteria (for adults and children)[46], and referring TB suspects for HIV testing;
- Treatment for Drug Sensitive TB in line ensure compliance with new treatment protocol and national SOPs.
- In Benguela province: A networked structure and support system will be set-up and closely monitored for diagnosing and treating TB and HIV i.e., "one stop shop" approach in TB/HIV, setting-up TB/HIV services in 1 prison for the first time, set-up network of BK-GeneXpert-LPA referral and counter-referral systems).

Capacity development

- In coordination with PEPFAR/CDC-funded partner, AFENET, support quality control of TB, TB-MR and TB / HIV laboratories, with implementation of QC in laboratories at the various levels of care in Benguela.
- Contribute to the national MDR/RR-TB detection target by expanding and strengthening the performance of existing GeneXpert sites, LPA, liquid and solid cultures laboratory services to improve MDR/RR TB/ XDR diagnostic services;
- Supportive supervision from national to provincial and provincial to municipality levels of programme implementation to ensure quality;
- Strengthen M&E of TB programme: Revising and re-printing guidelines/standards and record books;

[46] Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings, 2011 (see algorithm for adults pg8 and for children 15)

Target areas and populations

All those with presumptive TB or needing TB treatment as well as all adults and children at risk of MDR/RR-TB (estimated at 2.8% of new cases; 21% of retreatment cases notified), with focus on all contacts of MDR/RR-TB cases, and on Benguela province. All identified MDR/RR-TB patients will be put on second line treatment.

Community TB Care Delivery in Benguela province

Context

High LTFU rates lead to low treatment success rate and high MDR/RR-TB rates In Angola, LTFU rate was 22% in 2016, down from 25% in 2013. In 2015, the LFTU rate for RR/MDRTB was 11.3% (26 cases). Factors driving LTFU are well known in Angola. They include 1) ongoing stock-outs of first line TB drugs, 2) centralisation of the TB service network around sanatoriums and reference hospitals (until 2018), 3) length of TB treatment (until the new treatment protocol) 4) catastrophic costs (transport etc.) and last but not least, the quasi absence of community-based support to TB treatment compliance and completion.

Yet, it has been widely demonstrated that high LTFU rates can be reduced through patient centred care with community engagement, building capacity of community-based organisations (CBOs) and structured community groups to enhance community support and provide a package of treatment adherence interventions (TAIs)[47].

In 2019, a pilot community DOT intervention implemented in 6 provinces by SR CUAMM with ground-level implementers such as ADPP in Luanda, reported positive outcomes. Due to the early grant closure of NFM 2, it has not been assessed nor articulated into a national strategy.

Objective

In Benguela province and reducing LTFU; 2) to develop a one-stop-shop model and comprehensive diagnostic network in Benguela province.

Priority Interventions

In Benguela specifically:

Policy and advocacy

- Empowering communities and affected populations to form groups/organizations to work in TB and HIV programs.
- These CBOs will also refer presumptive cases, support contact tracing and treatment adherence, and raise overall health awareness;

Service delivery

- Delivery of patient-centred care with the options of treatment at or near home (DOTS-C supervised by family members, ex-TB patients, community treatment supporters) or at a nearby health facility;
- Community involvement for contact tracing;

[47] Guidelines for treatment of drug-susceptible tuberculosis and patient care (2016)

Target areas and populations

All those with presumptive TB or needing TB treatment as well as all adults and children at risk of MDR/RR-TB (estimated at 2.8% of new cases; 21% of retreatment cases notified), with focus on all contacts of MDR/RR-TB cases, and on Benguela province. All identified MDR/RR-TB patients will be put on second line treatment.

Addressing TB/HIV co-infection, with a focus on Prisoners in Benguela

Context

In 2019, 61,895 of 78,305 notified TB cases were tested for HIV. 4.700 were HIV positive, of whom 3 842 were on ART in 2019. There is no reliable data on how many PLHIV received IPT for possible latent TB among adults and childhood contacts of TB patients, nor on the number of PLHIV on TB treatment,

Low levels of TB screening and Isoniazid Preventive Therapy (IPT) (<10%) among PLHIV, low ~~HIV testing levels among TB patients (45%),~~ low number of patients with TB/HIV co-infection on both TB Tx/ART (10%) highlight the need for better integration of HIV and TB service provision, as well as integration of TB/HIV interventions in RMNCAH platforms. Adequate skills in the management of TB/HIV co-infection are also lacking among health professionals.

Objective to strengthen collaboration between TB/HIV programmes as well as the integration of TB/HIV service delivery in one prison in Benguela.

Priority interventions

Policy and advocacy

- Strengthen coordination and integration of HIV/TB activities at all levels (regular national, including Ministry of the Interior, and provincial level HIV/TB coordination and data review meetings);

Supply of health products

- Procurement and supply management of IPT to those meeting eligibility criteria.
- Procurement of Isoniazid to support 17,273 adults and 1,103 children under ART to prevent HIV/TB co-infection.

Service delivery

- Promotion of TB and HIV testing, with early initiation of ART for co-infected patients
- Screening for TB among PLHIV to ensure that at least 80% of PLHIV are screened for TB at every visit using the standard WHO-4 question criteria (for adults and children)[48], and TB suspects will be referred for diagnostic testing
- Provision of IPT to those meeting eligibility criteria.
- In Benguela, “One-stop-shop” HIV/TB service provision approach

[48] Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings, 2011 (see algorithm for adults pg8 and for children 15)

- Dispensing and follow-up with patients will be reinforced during the intensified municipal to health facility supervisions and on the job trainings.
- In Benguela province, follow-up and adherence support will be ensured outside of prison as well as contact/partner tracing;

Capacity development

- Promote joint support supervision (MOH Programmes, Ministry of the Interior) visits to the Benguela prison;
- Deliver HIV/TB joint training by the two disease Programmes, using integrated training modules at the prison;

Target areas and populations

Ppeople co-infected with TB and HIV and the population of the Benguela prison.

Health Management Information Systems and M&E

Context

The Angola Strategic Health Information System Plan (PESIS) 2011-2015 identified the following challenges specific to the National Health Information System[49]:

Limited data availability

- A significant proportion of health facilities do not submit reports at all or do not submit them on time;
- Medical doctors and nurses at health facility level often do not complete or partially complete the health facility data registers;
- Disaggregated reporting by age, sex, key population, sub-national data is by and large missing, making it difficult to design and target responses.

Multiple reporting channels

- Each of the MOH Programmes i.e. HIV, TB, Malaria, Sexual and Reproductive Health Epidemiological Surveillance, Expanded Immunisation Programme, Nutrition, Neglected Diseases and Hospital Assistance - has its own sub reporting system within the national health information system. This inevitably results in data discrepancies. A case in point is the difference between the TB indicators reported by the HIV and TB programmes;
- Poor regular and integrated monitoring between MOH Programmes and their international and national civil society partners.

Limited capacity and opportunities for data analysis and quality reviews

- Lack of professionals trained in statistics at all levels of the system. At the community level, math literacy is also poor;
- Data validation meetings at municipal, provincial or central level occur infrequently;
- Data quality assessments are usually initiated by donors and not routinely carried out by the MOH Programmes;

[49] PESIS (2011-2015) page 1

Objective

To increase data availability, quality, and capacity for analysis and use at all levels of the national health system by developing an integrated National M&E Plan and supporting the utilisation of the DHIS2 and OpenLMIS platforms.

Priority interventions will include*:*

At Central level

- Support the GEPE and the Programmes to develop an integrated, National M&E Plan with definitions, indicators, integrated supervision tools and quality assurance process. Both the HIV and Malaria Programmes have outdated M&E plans but the TB Programme does not have an M&E Plan at the moment;
- Join PEPFAR/USAID-funded efforts to ensure DHIS2 coordination mechanism is led by MOH/GEPE;
- Address technological issues within the DHIS2 system, as shown by the lessons learned from the DHIS 2 roll-out process (i.e., data harmonisation and integration coming from the various sub systems; standardise and decentralise data collection instruments and processes across all sub systems);
- Support the adaptation of data collection tools for reporting against the Performance framework indicators (Malaria, HIV and TB), including indicators for key and vulnerable population targets;
- Address interoperability issues between DHIS2 and the community HIS system for HIV and Cobocollect for Malaria;
- Support the usage of the DHIS2 "Dashboard" at National level to enable monitoring of the disease programme indicators and of international partners by central-level MOH actors;
- Integrate the TB modules into DHIS2.

At Provincial, municipal and health facility level

- Ensure frequent (monthly and/or weekly) routine supportive supervision visits by Provincial and Municipal Health Authorities to health facilities to ensure compliance with the national treatment guidelines for first line and second line regimens across Programmes;
- During supportive supervision visits, identify and correct of discrepancies between stock at hand data reported at health facility, provincial authority and central levels;
- During supportive supervision visits, coach provincial and municipal supervisors to conduct data quality review exercises at health facility level prior to insertion into DHIS 2 to improve on the transmission of the data from the primary sources (health facility registers) to the intermediary sources (municipal and provincial health authority reports);
- Institutionalise the importance of giving feedback by fomenting validation meetings at municipal level, involving representatives of the municipal health programmes;
- Provide logistics support to municipal health authorities and health facility focal points to be able to communicate regularly;
- Coach health facility staff on the importance of complete data collection instruments, patient and pharmacy records.

Target geographic areas and populations

All people affected by the three diseases will directly benefit from the improved health information systems proposed in the Z grant. Priority populations such as pregnant women, children, Adolescent Girls and Young Women, Female Sex Workers, People living with HIV, TB Patients, Men who have sex with men, and hard-to-reach communities with limited access to health

services will particularly benefit. Technical assistance efforts will be intensified in Benguela province.

Community M&E Systems

Context

Under NFM 2, efforts for the streamlining of reporting systems for community interventions were carried out. These led to the conception of Cobocollect for Malaria and the adaptation and transfer of the SIS Comunitário to the INLS.

Cobocollect for Malaria. Under DHIS2, the malaria template already includes 4 indicators under a "Malaria in the community" section. ADECOS report on the indicators below, all disaggregated by age, at the health facility located in their catchment area, who will in turn report to the Municipal level through DHIS:

- Number of malaria suspected cases in the community
- Number of cases tested for malaria in the community
- Number of malaria confirmed cases
- Number of malaria cases treated with ACT
- Number of malaria cases referred to a health facility

World Vision developed Cobocollect and has trained and supervised ADECOS on its use.

SIS comunitario for HIV, STI and GBV. Designed as an online individual patient tracking health information management system (HIMS) for HIV, STI and GBV services, the platform allows NFM2 UNDP SRs and SSRs i.e. as MSH, OIC, MWENHO ASCAM, APDES, to plan, integrate, measure and disseminate their contribution to the HIV programme. The platform also works as an HIV positive patient record system with the capacity to collect, store, update, and make available clinical information important to the delivery of patient care (i.e., consultation, laboratory and ARV drugs pick up information). The data is accessed online at www.linkagesangola.org and includes a linkage to ArcGIS maps to show geographic service coverage. The INLS and UNDP among other partners have viewing access to cumulative data by NGO partner, type of population, total numbers of patients by service and time period. In 2019, SSR ADPP began to also use the system and is in the process of adopting the risk assessment questionnaire for application with AGYW. The INLS and its partners are committed to linking this system to the DHIS2 system.

CUAMM, a TB partner in Angola, has also adopted SIS Comunitário and has been working with GEPE and the TB Program to incorporate TB indicators to monitor at the community level. INLS and GEPE's Plans to link the latter with DHIS 2 are also well underway. Additionally, the TB modules still need to be created within the DHIS2 system as reported in the previous module.

Objective

To integrate the data reported by NGOs and their health activists into the national health information system so that their contributions can also be taken into consideration and supported.

Priority Interventions

- Address interoperability issues between DHIS2 and the Sis Comunitário for HIV and Cobocollect for Malaria;
- In close collaboration with the INLS, PNLM, PNCT and GEPE support SSRs on the set-up of indicator and service definitions (as per changes expected in the minimum package of services for KPs and AGYW), alignment of data collection instruments and reporting on the system;

- Support the routine usage of system dashboards at all levels of the NGO SRs (from activistas to senior leaders) to steer programming;
- Support the usage of the DHIS2 "Dashboard" at National level to enable monitoring of NGO contributions to national HIV, malaria and TB goals;
- Fomenting validation meetings at community level, involving activistas (in Benguela) and representatives of the health facilities, municipal and provincial health programmes;
- Fomenting set-up of coordination meetings between NGOs and health facilities;
- Coaching SR staff on the importance of complete data collection instruments and adherence to national indicator and service definitions.
- M&E Capacity development interventions for SR and SSR as well as MoH staff

Target areas and populations

All people affected by the three diseases will directly benefit from the improved health information systems proposed in the Z grant. MOH priority populations i.e. pregnant women, children, Adolescent Girls and Young Women, Female Sex Workers, People living with HIV, TB Patients, Men who have sex with men, and hard-to-reach communities with limited access to health services, will particularly benefit. Technical assistance efforts will be intensified in Benguela province.

Program Management

Objective

The proposal for the Z grant, is that UNDP as the PR brings central, provincial, municipal, health facility and community levels together to implement a comprehensive response that addresses the common leadership and management challenges across disease Programs; encourages Programmes to leverage funding, drafts a common work plan and monitors it closely. We will only achieve improved performance across all three disease programs in the Z grant year if the response is well managed to avoid delays in funding transfers, patient-focused so that it provides comprehensive responses based on patient and not programme needs, and funds are leveraged across Programmes, so that underfunded Programs like TB can also achieve an ambitious agenda.

At the same time, given the planned move to the sub-national approach under NFM 3, closure activities will be initiated for the community component in the following provinces: Luanda, Huila, Namibe and Cunene.

Priority Interventions

- **Build a "PR-SR" type of relationship with the National Public Health Directorate (DNSP)** similar to the one it has with the INLS, through an MoU. This Directorate houses the Malaria and TB Programmes which report to DNSP. However, unlike that with INLS, the SR agreement with DNSP will involve direct payment modalities vis-à-vis the malaria and TB programmes. Given the Z grant short time span, avoiding lengthy approval processes is essential for the success of all implementers involved.
- In the same logic of reducing approval levels, UNDP pretends to **house the warehousing and distribution service provider contract under the INLS** which, unlike DNSP or the Malaria and TB programmes, has legal authority. The contract will the cover the three diseases (TB, Malaria and HIV). In addition to avoiding protracted payment and reporting processes, this should also foster integration between the three programmes through the collective review of quantification, procurement plans and stock reports.
- Advocacy will be conducted with provincial health authorities to adopt the TB/HIV/Malaria integrated implementation approach, and to high-level decision- and policymakers through

dialogue and consultative meetings for increased funding and investment commitments in TB/HIV/Malaria programs;

- Existing mechanisms (e.g. HIV/TB Technical Working Group - TWG,) will be strengthened to ensure effective coordination in all provinces;
- Still in line with the principle of integration which will inform the Z Grant, and in consultation with the Ministry of Health the scope of work (SOW) of GF-supported **OPPMs and HIV Regional Supervisors will be harmonised** into "OPMTV" or Provincial Officer for Malaria, TB and HIV. This will avoid having two distinct cadres of provincial M&E focal points under the same Grant. It should also maximise HMIS investments under the Grant.
- With support from the "OPMTV", increase oversight through joint TB/HIV reviews and supportive supervision in high burden provinces;
- In line with its "PR of last resort" role, UNDP will continue to invest in the **organizational capacity-building** of INLS through human resources-related investments and the development of internal control framework (procurement and set-up of the financial management software, Primavera); technical assistance in M&E, procurement and Financial management. The current GF-funded positions at central level will be maintained at the level of the HIV, Malaria and TB Programmes. To help them prepare for NFM 3 and/or Global Fund exit, **NGO SRs** and SSRs will continue to receive capacity development interventions either through **UNDP staff, SR mentors** in the case of SSRs or **external TA providers.**
- Under NFM 2, UNDP has hired **4 NGO Sub-Recipients** (ADPP, MSH, APDES), 1 FBO (Obra da Divina Providência) and 1 SSR under INLS (OIC) which have in turn recruited 301 Activists active in 16 Municipalities, located in 7 provinces. These Activists will continue to provide the following services.

Table 3: Community Interventions under the Z Grant

UNDP NGO Sub Recipients	Package of services	Provinces	Municipalities	Total number of Activistas
Organização de interação comunitária (OIC)	Prevention package for MSM and FSW including Peer education; referral for HIV testing and treatment services; group empowerment	Benguela	Benguela, Lobito,Catumbela e Baía Farta e Cubal	25
Agência Piaget para o Desenvolvimento (APDES)	Prevention package for AGYW, MSM and FSW including Peer education; referral for HIV testing and treatment services; group empowerment Community support package for access to PMTCT and adherence to ART	Bié	Kuito	24

UNDP NGO Sub Recipients	Package of services	Provinces	Municipalities	Total number of Activistas
Ajuda de Desenvolvimento do Povo Angola (ADPP)	Prevention package for AGYW including Peer education; referral for HIV testing and treatment services; life skills and leadership development Community support package for access to PMTCT and adherence to ART, including home visits, psychosocial support, referral to health services.	Benguela Huila Cunene Cuando Cubango Luanda Namibe	Benguela, Lubango, Ondjiva, Menongue, Namibe, Cazenga, Viana, Samba	160
Obra da Divina Providência (ODP)	Community support package for access to PMTCT and adherence to ART, including home visits, psychosocial support, referral to health services	Luanda	Kilamba Kiaxi	20
Management Sciences for Health (MSH)	Package of HIV services to FSW including peer education; gender-based violence prevention; linkage to psychosocial support; HIV post-exposure prophylaxis in cases of sexual violence; technical support to municipal police services; social behavioural change communication	Luanda	Ingombota, Kilamba Kiaxi, Sambizanga and Cazenga	72

- **The articulation of the community component with Disease Programmes**, which has been by and large lacking so far, will also be strengthened under Z Grant. HIV and TB NGO SR will have a reporting relationship with Programmes, alongside UNDP. Grant performance review meetings co-chaired by the Programmes and involving NGO SRs will also be held on a quarterly basis.
- UNDP is committed to nurturing the **strategic partnerships** which it has built since NFM 1. These include collaborative links with the PEPFAR and USAID -supported entities (namely, the PSM Project, ICAP, Health for All, m2m, AFENET), with ANASO Executive Secretariat, the UN Joint Team on HIV, the World Bank and the EU. Periodic formal and informal meetings will be held alongside the sharing of information critical for the success of the Grant. Such partnerships will also be leveraged at provincial level in the case of Benguela.

Target institutions

- The Ministry of Health i.e. DNSP, INLS, the Malaria Programme, the TB Programme, GEPE, GTI;
- Provincial Governorates and their Social Departments; Direção Provincial da saúde (Chefe de departamento da saúde publica; Pontos Focais Provinciais); Repartição municipal da saúde
- MASFAMU (Ministry of social and family affairs at central and provincial levels)
- MININT (Ministry of Interior at central and provincial levels)

- MAT (Ministry of Territorial Administration at central and provincial levels)
- NGO SRs : ADPP, APDES, ODP, MSH and respective SSRs
- Civil society networks at central and provincial levels, including ANASO.
- Bilateral partners and multilateral partners : PEPFAR and its partners (CDC, ICAAP); USAID and its partners (M2M, PSM Project; Health for All; AFENET); UNAIDS, UNICEF, UNFPA, WHO; World Bank; EU
- Private sector

Identified Risks and Mitigation Strategies

The table below presents the main risks identified by UNDP and related mitigation strategies.

Table 4: Main Risks and Mitigation Strategies

Area	Risk	Probability	Mitigation measure
SR engagement	Delayed engagement of DNSP due to bureaucratic issues and/or limited availability due to Coronavirus response	High	Start engagement process early (March-April) Draft and share MoU/SR agreement
	Delayed NGO SR re-hiring due to UNDP administrative processes	Medium	Start SR re-hiring / cost extensions now Complete Value for money exercises
Integrated approach	Business as usual, with reluctance to cooperate among programmes	High	Hold additional retreats / sessions to "sell" the integrated approach to Programmes
Benguela prioritisation	Investments of staff time and energy in Benguela adversely affect other grant components	Low	Complete Benguela set-up ASAP so as not to divert staff time away from other grant components
	Coordination issues with PEPFAR/USAID-funded projects in Benguela	Medium	Clarify roles and responsibilities Manage expectations
	Limited ownership by Provincial authorities	Limited	Start building ownership prior to 1st July
UNDP operational capacity	High levels of workload in July – Sept due to combination of Z grant start-up with incomplete recruitment processes	Medium	Advertise new or modified positions ASAP and complete recruitment processes before 1st July
	Limited operational capacity in Benguela due to unresolved start-up issues (staff, equipment, premises, funds)	Medium	Organise Benguela set-up ASAP: identify premises, recruit staff, transfer funds and equipment by early July

Trade-Offs Implied by the Consolidation of the Grants

The short lifespan of the Z grant forces UNDP to make certain trade-offs to its approach. These trade-offs are necessary in order to minimize delays in implementation. Every effort will be made to ensure that the quality of the programme is not adversely affected as a result.

1. **Work with select NGO/CSO sub recipients through a non-competed, sole source mechanism as opposed to an open bid.** While the process of re-hiring SRs already comes with its administrative challenges as indicated in the previous section, it is a much faster mechanism than having to do start an open bid process. The NGOs/CSOs selected to continue or to expand their presence in Benguela (MSH to support OIC and ADPP to implement community DOT) are experienced NGOs/CSOs with a demonstrated ability to have a rapid start-up of activities with quality. In order to minimize any potential backlash

from other NGOs/CSOs that may feel sidelined by the lack of an open bid process, UNDP will be transparent in its communications to the network of CSOs in Angola about the reasons why a competed bid was not possible at this time and it will also organize result-sharing sessions for SRs to share knowledge and lessons learned from the Z grant.

2. **Phase-out NGO SR activities in Luanda and selected provinces other than Benguela**: given the Global Fund's planned move to a sub-national approach, the Z grant period will be used to prepare NGOs implementing KP, AGYW and community support to PMTCT and ART activities in Luanda, Cunene, Namibe and Huila for the transition out of the Global Fund support. This will involve intensifying capacity development interventions during the last year of NFM 2, documenting and disseminating lessons learned, and mobilizing alternative resources.