



FY 2015 Angola Country Operational Plan (COP)

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Angola.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the “FY 2015 Country Operational Plan Budget and Target Report.”

Country Operational Plan (COP) 2015
Strategic Direction Summary
Angola

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Goal Statement

The goal of PEPFAR Angola is to:

Close significant data gaps, beginning with the DHS+, that will enable the Government of the Republic of Angola (GRA) to better understand, implement and monitor progress towards epidemic control in Angola and;

Develop best practice models in Luanda that the GRA can take to scale by improving the quality of clinical services for PLHIV in nine select high yield facilities through intensive mentoring, supportive supervision and enhanced technical assistance to address the gaps in the HIV cascade and by intensifying efforts to reach and link Key Populations (KP) who are disproportionately affected by HIV, through the cascade of care in selected sub-national units (SNUs).

The first step in achieving epidemic control is to better understand the Angolan HIV epidemic. PEPFAR is partnering with the GRA to complete its first-ever nationwide demographic health survey with biomarkers (DHS+) starting in August 2015 and ending in FY 2016. PEPFAR will conduct three Biobehavioral Surveys (BBS) with size estimation to: a) identify HIV risk factors b) provide an estimate of HIV prevalence among men who have sex with men (MSM), and c) provide an estimate of HIV prevalence among female sex workers (FSW). These surveys will inform further geographic prioritization to improve impact of KP interventions. The results of the FY 2015 military-based SABERS survey will also be finalized. SABERS will produce HIV prevalence and risk behavior data to allow for more targeted military programming. PEPFAR Angola will support the implementation of an electronic longitudinal information system (SIS) at the facility level to facilitate effective tracking of continuum of care activities and to optimize data flow and communication between patient registration, testing, laboratory, and pharmacy.

The second step is to improve treatment for PLHIV. PEPFAR Angola will assist the GRA to transform nine clinical sites in Luanda Province into 'model of service' sites that will consist of replicable health systems for HIV care and treatment. Based on international best practices, PEPFAR implementing mechanisms will provide facility level, intensive mentoring, supportive supervision and other services directly related to PEPFAR goals. To ensure quality implementation, acceptance of the model, and effective monitoring, PEPFAR will move into the selected sites in a phased approach beginning with an initial three clinics in the first quarter, three more in the second quarter and the remaining three clinics by the third quarter of FY16. Order of implementation will be determined in part by results of the FY15 baseline assessments, size of the clinics, and GRA input. Strategic laboratory and diagnostics strengthening will continue with a focus on CD4 and viral load. Supply chain management will continue at the above-site levels but PEPFAR will provide direct technical assistance only to select clinic-based pharmacies to create model of pharmacy management.

PEPFAR Angola will improve MSM and FSW testing and referral outcomes by focusing on targeted community outreach activities and referral to key population-friendly care facilities in

three municipalities (eight communities). Interventions will be aimed at improving identification, testing, and linkages to care & treatment, adherence and retention.

The nine clinical sites, excluding the military, will be in three municipalities within Luanda Province. Approximately 30 percent of Angola's population resides in Luanda Province; it is where the majority of PLHIV reside, and it is also where the largest HIV testing hospitals are located. In addition to the nine model clinical facilities and eight community sites, PEPFAR will also work in 14 above-site locations. PEPFAR Angola will provide limited technical assistance to government institutions to ensure financial sustainability of care and treatment models.

In Angola, quantifiable outputs and outcomes are expected by the end of the COP year of implementation under this consolidated and refocused PEPFAR approach. Targets have been set following a modified version of the 90-90-90 model that will allow a significant increase in PEPFAR's impact under the parameters of a technical assistance country. PEPFAR Angola is confident that this new pivot in strategy will not only produce quantifiable results but will also make the best use of resources and thereby assist Angola in its effort to contain the HIV/AIDS epidemic.

1.0 Epidemic, Response, and Program Context

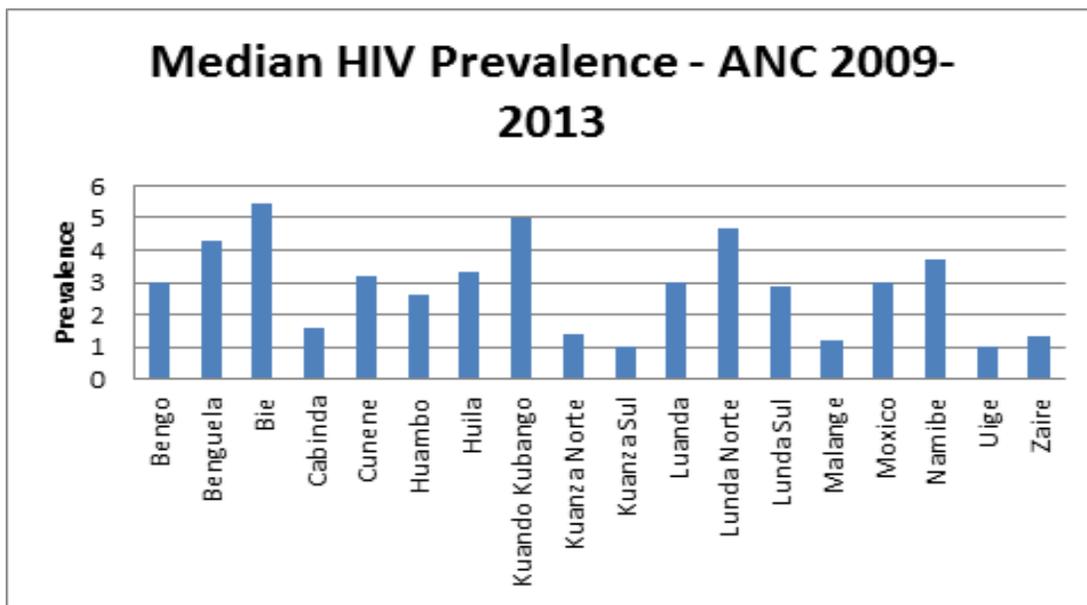
1.1 Summary statistics, disease burden and country or regional profile

Quality data that can be used to inform health programming in Angola is limited. There are no reliable population-based HIV surveillance data or other health data available to inform planning efforts. HIV interventions have been based on limited and inconsistent program data from the National AIDS Program (INLS), HIV sentinel site surveillance at antenatal clinics (ANC), and/or estimates from UNAIDS Spectrum projections (generated from those program data and ANC sentinel surveillance estimates).

Angola is thought to have a generalized, heterosexually-driven, HIV/AIDS epidemic with an adult prevalence of 2.42 percent. The 2014 preliminary Spectrum projections show there are 305,382 (242,189 adults [15-49] and 31,301 children) people living with HIV (PLHIV). Of those PLHIV, an estimated 180,253 (59 percent) are in need of antiretroviral treatment (ART). The ART coverage in HIV-infected adults was estimated to be 26.3 percent (72,066 adults on treatment). Coverage for HIV-infected children was 14.7 percent (4,600 children receiving ART). Adult ART is available at 155 clinics nationwide, pediatric services are available at 136 sites.

In Luanda Province, there are an estimated 91,560 (82,441 adults 15-49 and 9,119 children 0-14) PLHIV. Angola records the number of HIV positive tests, rather than the number of HIV positive individuals making it difficult to determine an accurate percentage of persons in care and on treatment. In 2014, there were 18,242 (11,994 adults 15-49, 2,643 children 0-14, and 3,605 pregnant women) recorded HIV positive test results. In the same year, 17,341 (10,288 adults 15-49 and 7,053 children 0-14) PLHIV were enrolled in care and 9,476 (6,121 adults 15-49 and 3,355 children 0-14) PLHIV were initiated on treatment.

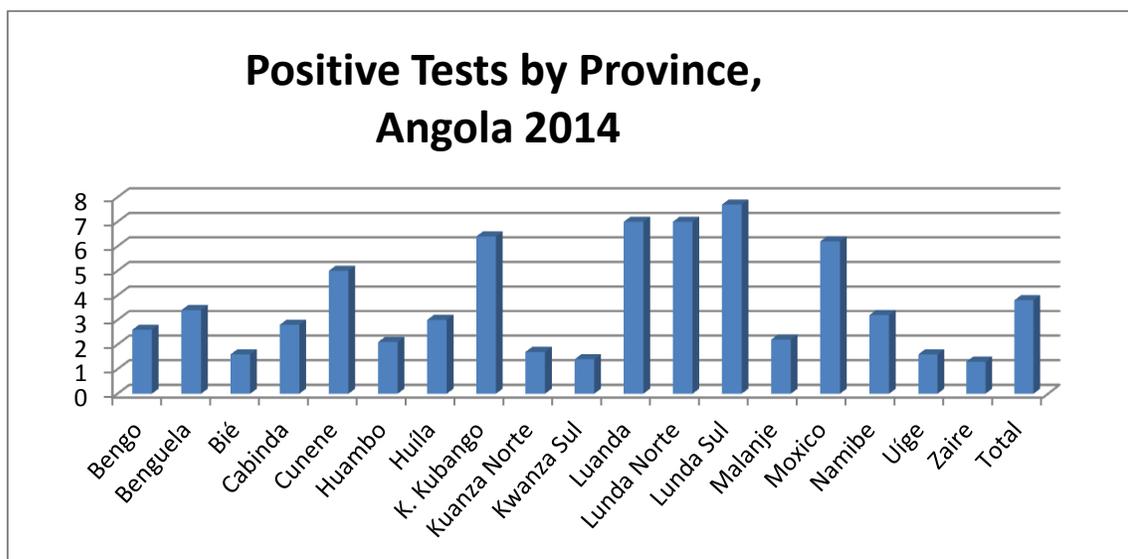
In 2014, approximately two-thirds of the estimated 1,146,985 pregnant women utilized public clinics, however less than 50 percent (545,958) were tested for HIV highlighting a gap between national policy established in 2014 and day-to-day reality. Of those tested, 1.94 percent (n=10,606) were HIV positive. Overall, HIV prevalence in pregnant women has remained stable between 2-3 percent since 2002. The median HIV prevalence of the 36 sites participating in the biennial ANC HIV sentinel surveillance was 2.24 percent.



Key populations have not traditionally been a focal population for the GRA. To date, there are two recorded HIV prevalence studies that have been completed including a 2010 MSM BBS in Luanda Province and a 2009 BBS among women engaged in transactional sex in Cunene Province. Both were limited in geographic focus and results from both have been critiqued. Utilizing global peer-reviewed literature on population estimates (2.0 percent MSM [Caceres, 2008] and 2.2 percent FSW [Vandepitte, 2006]) the number of MSM is estimated at 106,231 nationally and 28,970 in Luanda Province. The number of FSW is estimated at 124,540 nationally and 32,446 in Luanda Province. A 2008 UNAIDS report showed FSW HIV prevalence at 23.1 percent in Angola and peer-reviewed literature (Beyrer, 2008) combined with a general population male prevalence of 1.99 was used to calculate MSM prevalence of 7.22 percent. Using the prevalence estimates, FSW PLHIV is estimated to be 28,644 nationally and 7,463 in Luanda Province and MSM PLHIV is estimated to be 7,649 nationally and 2,086 in Luanda Province.

The HIV response in Angola is guided by the National HIV and AIDS Strategic Plan (PEN-IV), a four-year (2015-2018), multi-sector framework developed to help achieve the national priorities in the fight against HIV and AIDS. The PEN 2015-2018 strategic plan aims to increase ART coverage by 2018 to 90 percent in pregnant women, 45 percent in adults, and 80 percent in children.

Figure 1: Positive test (percentage), INLS, Angola 2014, by province



The key interventions, which need to be implemented in Angola to stem the spread of HIV, include (1) increased targeted HIV testing for key populations and other priority populations, (2) quality ART service access and retention (including improved adherence monitoring and a decrease in loss to follow up) for all those who are eligible, and (3) promotion of HIV interventions in KP after completion of size estimation and BBS. Gaps in the continuum of response cascade are evident. For example, HIV testing is still inadequate. At least a third of PLHIV are estimated to not know their status. Furthermore, routine external quality assurance of point of care HIV and CD4 testing is limited. Lack of viral load testing to assess adherence and effectiveness of ART has been identified as a key bottleneck in improving treatment outcomes and retention. Data gaps are a huge challenge, in particular for monitoring of ART adherence and retention. Other potential hindrances to the GRA's success in HIV epidemic control include the end of The Global Fund (GF) grant in 2014 (although a new GFATM HIV concept note has been submitted). There will be a gap in GF financing to GRA in 2015. The impact of the drop in oil prices on budget support provided for HIV/AIDS by the GRA is not yet clear, but there is already a reduction in funding for capital expenditures in health.

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total (all)		<15				15-49				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	2014 unless noted
Total Population	22406006	100	5232996	23.4	5296081	23.6	5050458	22.5	4960392	22.1	UNAIDS
Prevalence (%)15-49		2.42		NA		NA		2.84		1.99	spectrum
AIDS Deaths (2014)	12125		1528		1569		4226		3247		spectrum
PLHIV	305382		15499		15802		143337		98852		spectrum
Incidence (15-49) (2014)		0.24		NA		NA		0.28		0.20	spectrum
New Infections (2014)	28872										spectrum
Annual births	950179										spectrum
% >= 1 ANC visit	649,594	68.45	NA	--			NA	--			Nat'l Reprod. Prog. Final Report, 2013
Pregnant women needing ARVs	19187	68.8									spectrum
Orphans (maternal, paternal, double)	114195		NA		NA		NA		NA		spectrum
TB cases (2013)	60,807		500		300		25,648		34,359		GRA TB Report-2013
TB/HIV Co-infection	2,667	11*	NA	--	NA	--	NA	--	NA	--	GRA TB Report-2013 *24,239 (tested/HIV)
Males Circumcised	6,199,454	90			NA	--			6,199,454	90	UNAIDS, WHO 2007 Circ estimates for Angola applied to current male 15+ pop
Key Populations											
Total MSM	106,231	2.0									Caceres 2008 (Est – Africa)
MSM HIV Prevalence	7,649	7.22									Beyrer(OR3.8)/Spectrum 1.9 Male Prev
Total FSW	124,540	2.2									Vandepitte 2006 (Est Africa)
FSW HIV Prevalence	28,644	23.1									UNAIDS 2008, Angola
Total PWID	---	---									
PWID HIV Prevalence	---	---									
Priority Populations Military	100,000						1960	2	96,040	98	IRB submission for SABERS 2015

* NA – not available

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)

			HIV Care and Treatment				HIV Testing and Linkage to ART - 2014			
	Population Size Estimate	HIV Prev	Total PLHIV	In Care	On ART	Retained on ART 12 Months	Viral Suppression	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	(#)	(#)	(#)	12 Months	(#)	(#)	(#)
Angola Total population	22,405,890	2.42	242,189	34,536	14,625	12,400	---	1,001,441	46,800	14,625
Luanda 15-49	2,915,442	2.83	82,441	10,288	6,121			103,882	11,994	6,121
Luanda 0-14	3,074,694		9,119	7,053	3,355			16,517	2,643	660
Luanda Pregnant Women	310,979	2.42	Incl. in 15-49 above	Incl. in 15-49 above	Incl. in 15-49 above			125,287	3,605	3,043
Luanda MSM (15-49)	28,970	7.22	2086							
Luanda FSW (15-49)	32,446	23.10	7463							
Luanda TB	21,263	11	2,339							
Angola Military	100,000	3.5*	3,500*					10,376	363*	

*MSM, FSW, and Military numbers are estimates

1.2 Investment Profile

From 2011-2014, the GRA, through INLS, increased funding from 58 to 72 percent of the total funding allocated for the HIV/AIDS response. The percentage provided by the GRA is actually higher when expenses for HIV/AIDS activities outside the INLS budget envelope are taken into account. With decentralization in Angola, salaries at the provincial and municipal levels are one of the largest expenditures outside of INLS.

PEPFAR is the only bilateral program that substantially supports the Angolan HIV/AIDS response. At a budgeted \$17,700,000 per year, PEPFAR's contributed expenditures were roughly 22 percent of the total HIV/AIDS national program budget for 2013 and 2014. Other multinational programs through the United Nations contribute about \$1 million per annum, or less than one percent of the estimated total HIV/AIDS national program budget.

The Global Fund has historically been a key donor partner to the GRA and was the second highest funder after the USG. The Global Fund Prime Recipient, UNDP, ended activities in December 2014. A concept note, based on the new funding mechanism, was submitted in April 2015. If the concept is accepted and approved in a relatively quick timeframe, Global Fund has stated that it would expedite payment. Therefore, the earliest that Angola can receive funding from the Global Fund would be third quarter 2016. The new funding request to the Global Fund involves procurement of medications and testing supplies, areas that until recently were not thought to be supported in the next round. As shown in table B, the GRA finances the largest percentage of care and treatment which involves procurements. External donors have historically supported prevention activities.

The predominant issue facing PEPFAR's role in support of achieving epidemic control in Angola involves the macroeconomic instability and subsequent revenue uncertainty given sharply declining oil prices internationally, and limited external donor investment. Angola's oil industry accounts for about 50 percent of GDP and 80 percent of tax revenues. The 2015 GRA budget was revised down in February 2015. Estimated revenue fell from \$39 billion to \$25 billion while gross expenditures fell from \$48.7 billion to \$32.7 billion in the revised budget. The exact percentage has not officially been released. Although much of the health sector budget seems to be largely unaffected in 2015, capital projects have been downsized, postponed or eliminated. This could affect access to health services in some areas of Angola. To date, the GRA has not stated whether it will revise the budget in the National Health Development Plan—long-term strategic guiding document.

If macroeconomic instability continues, the HIV/AIDS program could be compromised, as budget responsibilities will rise substantially. Increased linkages of PLHIV to care, treatment and other HIV/AIDS services could strain the national budget and compromise the life-saving services such as life-long ART. Risks to success for PEPFAR Angola include, but are not limited to: GRA's inability to procure increased supplies of drugs and commodities, GRA's lack of ability to plan and execute strategic information for monitoring and evaluations, and continuing downward trend of external donor investment in Angola.

Table A. Historic Financial Investment in HIV/AIDS in Angola

Funder	2011	% of investment	2012	% of investment	2013	% of investment	2014	% of investment
GRA	\$21,463,000	58%	\$32,757,129	63%	\$48,959,247	66%	\$50,192,321	72%
PEPFAR	\$11,856,677	32%	\$18,266,677	35%	\$16,071,044	22%	\$15,175,069	22%
Global Fund	\$263,000	1%	\$ -	0%	\$8,500,000	11%	\$2,908,657	4%
Other Donors	\$3,153,000	9%	\$1,000,000	2%	\$1,000,000	1%	\$1,000,000	1%
TOTAL	\$36,735,677		\$52,023,806		\$74,530,291		\$69,276,047	

*GRA from INLS budget report 2014; PEPFAR and 2011 from OGAC; 2014 Global Fund Report total Oct 2012- Sep 2014 is \$11,408,657; Other donor 2012 - 2014 are estimates

**GRA amounts do not include all HIV related expenses such as provincial/municipal salaries

Table B. Percentage of Disbursement in key areas 2009 – 2011 (GARP 2014)

Areas	External Resources			Host Country Government		
	2009	2010	2011	2009	2010	2011
Prevention	46.2	51.5	63.5	32.9	22.1	17.8
Care and Treatment	23.2	1.4	0.8	29.8	52.3	52.9
OVC	4.27	9.2	3.73	0	0	0
Program management	8.89	12.5	11.9	37.4	15.0	19.4
Human Resources	10.2	11.8	9.2	0	10.3	8.2
Social Protection (except OVC)	0	0.02	0.9	0	0	0
Assistance to people living with HIV/AIDS	4.0	4.3	4.9	0	0	0
Studies/surveys	2.9	9.0	4.8	0.2	0	1.5

Table 1.2.2 Procurement Profile for Key Commodities¹

Program Area	Total Expenditure	percent PEPFAR	percent GF	percent GRA	percent Other
ARVs		0		100	
Rapid test kits		0		100	
Other drugs		0		100	
Lab reagents		0		100	
Condoms		0		100	
VMMC kits		0		100	
Other commodities		0		100	
Total				100	

**Prior to December 2014, Global Fund supported 40percent of ARV and rapid test kits*

Table 1.2.3 Internal USG Program Integration and Leveraging

	Total Investment	Leveraged Funds	PEPFAR In-country Contribution	# of IMs	Notes
USAID MCH	\$1,000,000				
USAID TB	0				
USAID Malaria	\$29,000,000				
NIH	0				
CDC NCD	0				
Peace Corps	0				
DOD Ebola	0				
Millennium Challenge Corp.	0				
Private Sector	\$150,000	\$50,000			
PEPFAR Central Initiatives					
Total	\$30,150,000	\$50,000			

1.3. National Sustainability Profile

Results from the Sustainability Index and Dashboard (SID) demonstrate three broad areas of the national HIV response that are unsustainable. They are 'Technical Efficiency' under the Health Financing and Strategic Investments section; and 'Public Access to Information' and 'Oversight and Accountability' under the Accountability and Transparency section. The category of accountability and transparency are broad areas that not only affect health but other parts of government as well.

To address accountability and transparency, PEPFAR Angola will encourage regular stakeholder meetings to identify gaps in government reporting and supporting the institutionalization of national monitoring systems that are widely disseminated. SIMS has changed the way in which PEPFAR engages with the government to one that is a participatory partnership to build capacity as well as instill sustainable practices into local institutions. The

choice to focus funding only on core and limited near-core activities will increase the depths of PEPFAR Angola's impact and promote sustainable change.

While the SID shows a respectable epidemiological and health data score of 10.6; it should be noted that the quality of data needs to be vastly improved to support a sustained response to the HIV epidemic. A core activity will be to strengthen SI and data collection in Angola. PEPFAR will assist with collection, analysis and use of health data for performance improvement and epidemic control.

Success of the GRA's HIV Control Program, in general, is dependent upon the ability of the government to continue to provide increasing financial support to the growing numbers of people placed on treatment. The impact of the drop in oil prices on GRA HIV funding support could have a huge impact on allocative and technical efficiencies under the domain of health financing and strategic investments. Additionally, the quality of the data must be urgently improved before the HIV epidemic can be fully understood in Angola.

PEPFAR will continue supporting sustainable health financing through strategic planning and budget formulation exercises at municipal levels. USAID and the World Health Organization are currently preparing to support the re-establishment of National Health Accounts in the Ministry of Health. USAID and the Department of Treasury also work with the Ministry of Finance on general accountability and transparency reforms with a focus on improved public financial management in the health sector. The European Union provides long-term technical assistance and training to strengthen national health information systems and other policy reforms.

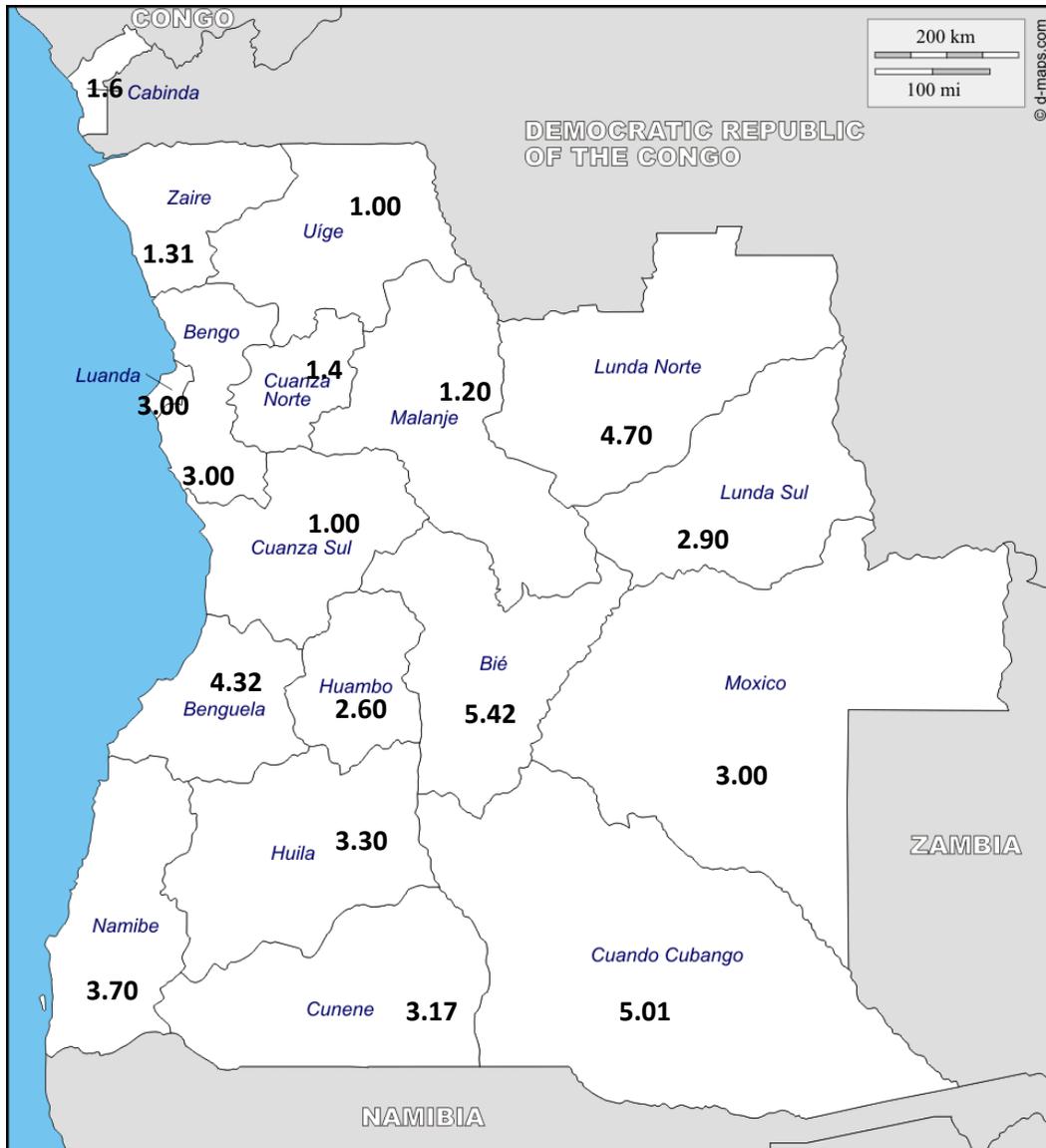
1.4 Alignment of PEPFAR investments geographically to disease burden

The disease burden is difficult to measure at this time with the lack of population-based health/HIV data, but this will be addressed by the DHS+ to be implemented in FY2015/16. Additionally, while HIV program data is collected at every clinic it has traditionally been difficult to access and is of questionable quality. In lieu of a traditional DHS+ and other HIV surveillance and survey data, PEPFAR will use proxies including ANC data gathered in 36 sentinel sites nationwide. These data are represented in the map within this report. Based on the results of the 2013 round of ANC sentinel surveillance the GRA prioritized nine of the 18 provinces in Angola for its rollout of Option B+ in 2013, including Luanda. The eight ANC sites in Luanda Province ranged from 1.4 to 4.7 percent.

PEPFAR Angola has chosen to focus activities in Luanda Province to implement models of service sites in a phased approach. Key factors in choosing Luanda were: almost half of the country's PLHIV burden, estimated higher numbers of KP (based on PEPFAR Angola programmatic data and experience from other African countries showing higher KP population in capital cities/urban areas), limited PEPFAR funding in conjunction with high travel costs and overall costs of doing business in Angola, and increased accessibility for implementing partners and USG. The program will assess data and size estimations as they come out from the DHS+ and BBS for key populations in Bie, Benguela and Cunene that might require programmatic pivots. After completion of implementation in the nine sites in Luanda Province, successful

components of the model of service may be expanded to other high volume sites outside Luanda by the GRA.

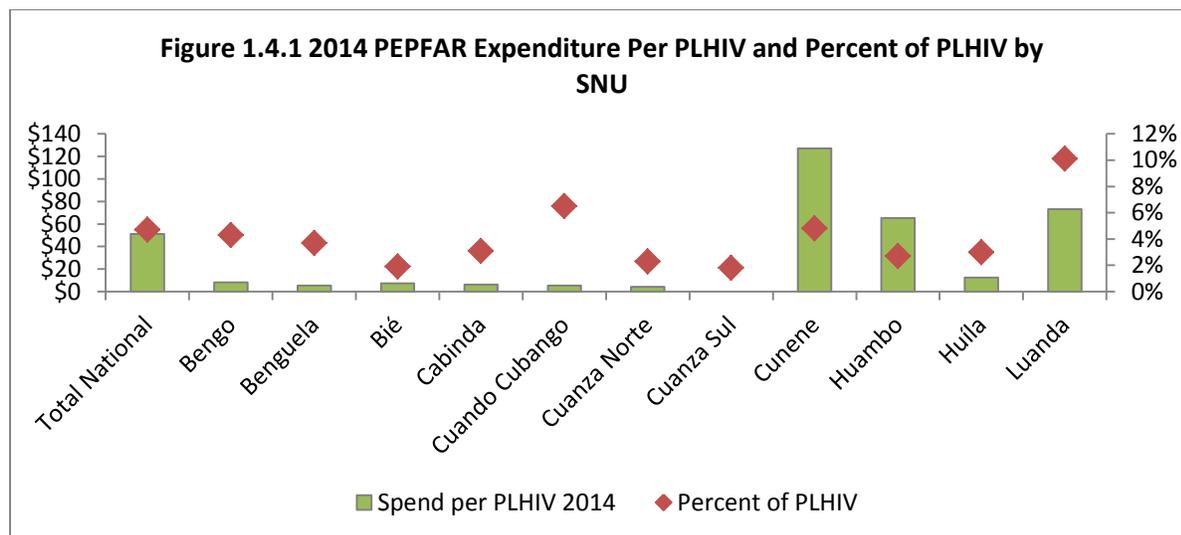
Figure 1.3.2 HIV Prevalence by Province, ANC Median Prevalence 2009-2013



FY 2014 PEPFAR expenditures per PLHIV data were compared with 2013 ANC HIV sentinel surveillance site prevalence (where >1 ANC site in a province, the median prevalence data for the province are presented). Figure 1.4.1 provides justification that expenditures should follow the burden: The pivot in COP15 is focused on Luanda municipalities with the most PLHIV. Figure 1.4.1 and 1.4.2 compare PEPFAR expenditures in 2013 to burden of disease by province. Expenditures per PLHIV ranged from \$0 in Cuanza Sul to \$127 in Cunene. In FY2013, PEPFAR Angola invested funds in 10 of 18 provinces; with an average cost of \$47 dollars per PLHIV.

Overall expenditures do not correlate between PEPFAR spend per person, PLHIV, and prevalence of HIV. Some provinces have a disproportionately high spend level (Cunene and Huambo) while others have a disproportionately low spend levels (Luanda and Cuando Cubango). Total PMTCT expenditures by ANC prevalence in 2013 were reviewed. Overall expenditures did not correlate with ANC prevalence.

The table below maps the expenditures against ANC prevalence data.



1.5 Stakeholder Engagement

PEPFAR Angola has been in constant dialogue with the INLS since the arrival of the new U.S. government Global AIDS Ambassador in mid-2014. The PEPFAR team introduced the new vision for PEPFAR globally and how it might apply to Angola given the program’s targeted technical assistance model, and gained initial buy-in for a revamped approach. After the COP 14 revision exercise in August 2014, the PEPFAR Angola team presented the conclusions from the Washington meetings to the GRA and has since charted the PEPFAR pivot jointly through routine engagements. KP and care/treatment technical working groups (TWG) from HQ have also participated in meetings with GRA. The PEPFAR Coordinator has been active on the CCM during the past year, having had coordination with Geneva as well as the Secretariat for the Country Coordination Mechanism (CCM). The COP 15 plan has been shared with the CCM with the intention to have a more synergistic approach with the Global Fund proposal currently under development and due in April. The new program focus and Sustainability Index (SID) were shared with the Global Fund CCM. UNAIDS was invited to participate in the review of the SID. The PEPFAR team met with a Civil Society umbrella organization to discuss HIV/AIDS work in Angola and to share the proposed COP 15. PEPFAR agencies have also met with select private companies.

Angola has not been identified as a Country Health Partnership (CHP) country in the near term but many efforts in COP 15 would be foundational to a CHP. One of the hallmarks of the proposed new programming is to build model systems that can be replicated by MINSA. The models of service would be models that are transparent and financially measurable. If successful, MINSA would replicate in other provinces with similar results of improved quality data for decision-making, high quality care and treatment services and ultimately reduction of HIV rates.

2.0 Core, Near-Core and Non-Core Activities

PEPFAR Angola examined FY 2013 program activities and categorized them as core, near-core and non-core in August 2014.

Further realignment occurred after taking into account recommendations stemming from the KP TWG, and the Care and Treatment TWG country visits in February 2015 in defining core, near-core, and non-core activities for program implementation in FY 2016. As a result, PEPFAR Angola's core activities will focus on: SI, care and treatment of people living with HIV, KP, laboratory strengthening, supply chain strengthening and military priority population.

To address data gaps, PEPFAR will work with Angolan counterparts to improve data quality, documentation and use at clinical sites. PEPFAR will conduct special surveys among KP (formative research, mapping, size-estimations and BBS), lead the first-ever DHS+ in Angola and complete the SABERS that is currently underway with the Angolan Armed Forces (FAA). The need to improve overall information systems will be done through the introduction of SIS and data entry training and mentoring using data specialists. Improvement will begin with a focus on review of manual/paper data. A dual system of manual/paper and electronic data collection system (SIS) from site to central levels will be established in the first year. SIS will be the base for the development of an electronic longitudinal information system to complement existing MINSA systems.

The GRA has only recently recognized the importance of KP programming, and as such the USG will build the capacity of civil society organizations (CSOs) and health care workers to ensure KP are reached, supported and monitored appropriately. Enhanced linkage to testing, care and treatment for KP will be developed in eight high yield communities in an effort to increase ART coverage. PEPFAR Angola will also help select clinics and CSOs to address stigma and discrimination at the clinic and community level.

PEPFAR Angola will work with the GRA to increase ART access through: improving quality of testing, care and treatment services for PLHIV at high volume sites, increasing the number of HIV+ mothers effectively transferred to adult C&T services after delivery, increasing availability of HIV-related supplies and pharmaceutical. Additionally, adherence and retention remain key quality of care issues in clinical programming for PLHIV. Patient Assistant Facilitators (PAFs) will work in conjunction with each facility's clinical teams to ensure adherence and retention in care through support services provide active case finding of those lost to follow up. Quality

laboratories and diagnostics support are critical to the continuum of care. Without CD4 and VL testing, it is not possible to initiate or monitor treatment or adherence.

PEPFAR Angola's relationship with the military is strong and continues to focus on the strengthening of military health systems dedicated to HIV prevention, care and treatment. Based on the results of the current SABERS study among the Armed Forces in Angola (FAA), programming will be targeted to address military units and locations that show the highest prevalence and risk profiles. The military is recognized as a priority population in Angola, and with support from the USG, military populations will be targeted for testing and linked to care and treatment facilities within the military health structure. Support for the military will also include targeted prevention activities, including condoms, laboratory support and quality assurance for military treatment sites.

3.0 Geographic and Population Prioritization

Based on Angola's epidemiologic program data from 2014, eight provinces represent 82 percent of the disease burden where only 23 percent of total PLHIV are currently on ART. Four provinces are located along major transport corridors and are considered hot spots for KP (FSW and MSM). As a result of this analysis and the country context, PEPFAR Angola has prioritized an appropriate mix of core activities targeting exploratory studies among KP and care and treatment activities focused within the capital province. Luanda represents 46.5 percent of total PLHIV burden. To reach epidemic control, PEPFAR Angola will work with the GRA, after successful aspects of the model are identified, to transfer the models of HIV care and treatment to other scale-up provinces.

PEPFAR Angola will implement a phased approach to institute foundational, high intensity support in nine identified clinics/hospitals in Luanda. In the first two quarters of FY 2016, PEPFAR will initiate services in up to six clinical sites. These sites were chosen based on numbers of adults, pregnant women and children tested and overall positivity. The greatest weight was placed on adults, followed by children, then PMTCT clients. Sites were also selected by the breadth of services included in the continuum of care. They were also selected based on proximity to known KP groups. Intangible criteria such as willingness of clinic leadership to work with the new model were taken into account.

In the model of service sites, PEPFAR expects to see a measurable increase in testing, persons enrolled in care, and persons initiated on ART. These increases will contribute towards an eventual 90-90-90 goal. PEPFAR Angola is confident that this new pivot in strategy will not only produce quantifiable results but will also make the best use of resources thereby assisting Angola to contain the HIV/AIDS epidemic.

PEPFAR Angola will adjust KP activities in selected districts within the province of Luanda based on the results of baseline assessment implemented in 2015 and to align these with the selected treatment sites ensuring identified HIV+ KP are enrolled and uptake complete continuum of care and treatment. To improve sustainability as well as retention in care and

treatment, PEPFAR will work closely with communities and civil society organizations within selected communities (districts) to address stigma and discrimination. Program pivots to other scale-up provinces will remain an option and will depend on DHS+ and BBS results.

Testing of military personnel will target high yield units and sites based on the 2015 SABERS results. An estimated prevalence of 5 percent of those tested will be initiated into care and support services and of that group 45 percent will receive ART at military health facilities. The overall military population that is currently on treatment is not released, but this approach will support the initiation of 43 percent of the military HIV+ population into care and treatment services over the next two years.

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Priority Populations

The Angola PEPFAR program will be implemented at three levels: facility, community and above-site. The facility level will concentrate on producing model sites in nine select clinical facilities, hospital and clinic. Model sites are health facilities that provide quality HIV/AIDS services based on highly functional systems and including capable human resources. Successful aspects of the models can be replicated throughout the country by MINSA with the resulting impact of lowering incidence and prevalence. Examples of systems that will be addressed in the facilities are: health information management, quality assurance, logistical/pharmaceutical, clinical competency, effective testing and linkage strategies, case management, retention mechanisms, and laboratory management activities. Each model site systems strengthening activity will be developed individually based on findings from the FY2015 baseline assessments. For example, in some clinical sites, the entire HIV clinical care cascade requires support; in others, only the adherence/retention component of the cascade will be addressed. Within a model site, there will be a minimum of three implementing partners working. The expertise and scope of work of each IP will be deployed to select and non-duplicative gaps within the cascade.

Adult care and treatment interventions are new focus areas for the Angola PEPFAR team. The current IP, who will provide technical assistance at the facility level, has worked for over four years with INLS and MINSA and is strong in combination prevention and health systems. A new IP will be introduced in the Angolan context to begin establishing operations and complement assistance in care and treatment services. Previous experiences registering new partners showed the process to be cumbersome, bureaucratic and lengthy. In March 2015, the GRA added measures of scrutiny to the registration process as a means to combat money laundering and international terrorism. There is uncertainty about the impact the revised regulations will have on PEPFAR's new IP registration but it is expected to lengthen the process. The team is working with the GRA to explore the possibility of obtaining a provisional approval to operate while the full registration process is underway. Until the new IP obtains at least provisional approval to operate, they will not be able to undertake start-up actions, such as hiring local staff or leasing office space. The provisional approval process could also be adversely affected by the new GRA regulations. Based on the lack of rapid registration and the need for the new IP to

build relationships with the GRA, the team will work with the existing IP to initiate adult care and treatment interventions in the nine sites. The existing IP has substantial experience working with and access to MINSA leadership at the national, subnational and site levels. In Angola, strong relationships are absolutely critical to the successful implementation of any program. The existing IP also has deep pool of technical experts to bring in additional skill sets necessary on the ground to begin implementation. The new IP will also work alongside the existing IP in the context of the Interagency Working Group to provide complementary training and services.

Working in eight selected communities where there are four model facilities in Luanda, the KP IP will provide mentoring and training to create a model to improve KP enrollment in the HIV/AIDS continuum of care.

PEPFAR Angola will work in 14 above-site locations. These sites include national warehouses, national laboratories and municipality/district governments located in Luanda province and having synergy with the model sites.

4.1 Targets for scale-up locations and priority populations

Target selection was done based on the best available INLS program and PEPFAR data for both clinical sites and KP community work. Most targets have been selected based on information generated monthly at clinical sites and reported through SIS. The process used to generate targets for COP15 is outlined below:

- 1) Estimated the approximate number of PLHIV in Luanda Province. This was done using ANC 13 prevalence and applied to the 15-49 year old population of Luanda Province (using 2014 census estimates). The resulting number was 82,441.
- 2) SIS reported data was used to determine an approximate number of persons who know their status, entered into care, and were initiated on treatment (15,599 tests reported positive in 2014; 10,288 linked to care; and 6,121 were initiated on ART).
- 3) As a TA country the 90-90-90 targets were adjusted to more accurately/realistically reflect PEPFAR TA impact. This was done by initially setting targets at 60 of the 90 percent.
- 4) Finally, targets were modified to account for differences between register counts and SIS reported data, partner experience in the clinics, and “on the ground” realities of working in Angola. It is expected that targets may change one final time after completion of baseline assessments in summer 2015 which will include in depth register and data reviews.

Community level KP targets were based on previous programmatic data from a legacy implementing mechanism.

Baseline assessments will be conducted in the nine model sites in COP14 so that impact from PEPFAR investments can be more accurately measured. A major component of the Angola pivot will be to work with KP and priority populations to make sure they are tested and that they are linked to care and treatment services.

Testing and HIV prevention activities have increased in previous years to reach a larger share of the military population. COP15 targets will be based on SABERS results and military priority, in terms of geography and military risk profile to be achieved. Additional indicators have been added based on feedback from the care and treatment TWG visit and from headquarters. Military HTC targets were based on the military's ability to reach 15 percent of their highly mobile and geographically diverse population.

The primary technical assistance targets selected include: number of people tested and knowing their status (HTC_TST); new and current people on ARTs (CARE_NEW, CARE_CURR, TX_NEW, TX_CURR); key and priority populations receiving targeted interventions (KP_PREV, PP_PREV); and the number of laboratories meeting international standards providing quality HIV testing (LAB_ACC, LAB_PT, LAB_CAP). PEPFAR Angola selected these indicators in line with the pivot to support only core and near core activities at a limited number of sites. There will be additional level three indicators that will measure other important progress and outcomes.

A critical assumption is that the Angolan government will continue to see efforts towards epidemic control as a priority for the country. The national government providing firm and demonstrated commitment to regular procurement of ARVs is essential as the number of people recommended for treatment in the select clinics increases. Another critical assumption is that municipal governments will adequately fund clinics within their responsibility areas for non-ART expenses such as staff salaries, equipment, and other local expenses in the wake of significant expansion. Due to decentralization, these expenses are funded outside of the INLS budget line.

Challenges to successfully meeting targets include negotiating a complex supervision structure with the Angolan government that has INLS and government bodies at the national, provincial and municipal level all providing oversight to local clinics. Working with clinic staff who might be resistant to implementing new procedures and expectations that could be perceived as increased responsibilities without increased compensation may also be a challenge. There will be a short-term need to complement existing facility staff to show effectiveness of a model site. This is not always sustainable and will need to be evaluated periodically for ways to improve and reduce the sustainability burden. Within PEPFAR, this new model will require substantially greater coordination with interagency implementing partners.

Population-based health data gaps at national and sub-national levels will be considerably reduced with the DHS+ completion, with a first draft expected in April 2016 and final publication by September 2016. Efforts are underway to improve the significant KP data gaps with a BBS survey starting in August 2015. Preliminary results for Luanda are expected by December 2015 and for Bie, Benguela and Cunene provinces by September 2016. PEPFAR will provide technical assistance to the INLS and target facilities to develop a longitudinal information system in COP15.

With the targeted focus reduction from over 240 limited technical assistance sites to nine model of service, all health-systems supported sites, PEPFAR will realize significant gains in the focus of technical assistance. PEPFAR will quickly demonstrate quantifiable impact for epidemic control and realize replicable models that the GRA can scale-up in other provinces. As this is a model of best practices that has not been done for HIV programming in Angola before, PEPFAR

and its implementing partners will work closely with the GRA to implement. As it is highly likely that all components of health systems in each model site will not need equal attention, the need for continuous monitoring and evaluation of the project is even more critical. Those model systems that have shown significant effectiveness will be slated for scale-up.

The expectation is that with targeted technical assistance at a key number of clinical sites through a phase-in approach, PEPFAR will demonstrate replicable success in foundational health systems that work toward containing the epidemic. The USG is the only partner working with services to key populations that includes identification, testing, and linkage to care/treatment. PEPFAR expects significant improvement in quality of data related to KP over the coming years through the BBS survey and after full IP implementation is underway.

4.2 Priority population prevention including key populations

Based on available data in Angola, updated geographic focus, and results from the core, near-core, and non-core analysis, PEPFAR Angola proposes to invest in the following prevention interventions to accelerate epidemic control: increased counseling and testing among the military (priority) population and linkages of FSWs and MSM to services in the HIV continuum of care. PEPFAR Angola's decision to focus on this area is based on the best available knowledge regarding KP and current coverage gaps for military personnel. Based on SABERS data, COP15 will target military populations with the comprehensive HIV prevention in scale-up locations as a piece of the military's combination prevention approach.

PEPFAR will identify transmission dynamics and key "hot spots" within eight communities in Luanda to define appropriate interventions. PEPFAR will also provide technical assistance and training to establish specialized service provision for KP. The IP will also advocate for and support expanded access to respectful and confidential services delivered by well-trained providers on risk assessment, risk reduction planning, promotion of partner testing and counseling, condom use, syndromic screening and referral for STI. At the community level and to facilitate program sustainability, PEPFAR Angola will build upon previous capacity development initiatives to further strengthen CSO organizational performance and competency thus closing leaks in the continuum among KP.

4.3 Voluntary medical male circumcision (VMMC)

Based upon current data and priorities in Angola, VMMC is a non-core activity; therefore, the PEPFAR program will not support VMMC.

4.4 Preventing mother-to-child transmission (PMTCT)

Based on Headquarters guidance for TA countries, PEPFAR Angola will no longer directly support PMTCT activities in COP 15. Depending on DHS+ results, PMTCT activities could be re-started in a later COP year. There will be support to adherence and retention services directed at postpartum women.

4.5 HIV testing and counseling (HTC)

Utilizing available site level data, PEPFAR Angola realigned geographic focus initially to select municipalities in Luanda province with specific emphasis on clinics with the highest positivity rates. PEPFAR will provide enhanced technical support to nine high-yield clinical sites. Among these nine sites, PEPFAR will design and implement an effective HTC replicable model that can be utilized by the GRA in the future. Each of the nine model sites will be customized based on the findings from the baseline assessments. External quality assurance during the implementation of point of care testing will occur at all sites supported by PEPFAR. PEPFAR will intensify the implementation of Provider-Initiated Testing and Counseling (PITC) strategy in key high yield areas of the facilities as an effective approach to improve case finding. Additionally, PEPFAR Angola will also support increased uptake of HTC amongst tuberculosis (TB) patients, the military, relatives of pregnant women, and PLHIV already in care and treatment services.

In select high-yield facilities and communities for KP, PEPFAR will improve on-site and off-site strategies and procedures, creating a model for voluntary counseling and testing (VCT) among key populations. PEPFAR Angola will significantly focus on VCT among KP using peer-based activities and mobile clinics to increase the number of persons on treatment for further epidemic control. PEPFAR will prepare health facilities to effectively provide care and treatment for KP. Additionally, a focus on improving the linkage between clinical and laboratory settings will increase the GRA's capacity for HIV testing. The military personnel will be targeted for prevention education and HTC based on the results of the current SABERS study.

PEPFAR Angola's approach will include enhanced support for on-site mentoring; on-going training and supervision on HTC services; development and implementation of guidelines and tools to increase testing among priority populations; improved systems of linkages from HTC to care and treatment services; improved referral/counter-referral procedures from community to facility services based on the continuum of care; and enhanced facility and central level supervision efforts to track HTC activities.

One important challenge in Angola is the targeted enrollment of partners and family members. PEPFAR will assist high-yield facilities to develop and implement methods to effectively increase the number of family members receiving HIV/AIDS services. This activity will be part of a more comprehensive HTC service model in Angola. PEPFAR will use PAFs to increase recruitment of partners and family members of HIV+ pregnant women and PLHIV already in care and treatment services.

4.6 Facility and community-based care and support

PEPFAR Angola will place increased emphasis on reassessing those on care who may now be eligible for ART, and better quantifying current on care and treatment service numbers. The refocused HIV pivot to care and treatment and the continuum of care across community and facility settings is a vital component to help drive down the Angola HIV epidemic.

New national guidelines for adult and pediatric populations will be considered during implementation of care and treatment activities. PEPFAR will provide on-site training and

continuous mentoring to facility-based health providers to improve care service delivery for HIV+ adults and children in nine high-yield facilities of Luanda. Through PEPFAR implementing partners, the focus will be on activities that create a model of comprehensive HIV/AIDS care service at the facility level, including but not limited to: testing for HIV in high yield locations with linkages to care and treatment services; initiation of ART and ongoing provider treatment follow up; management of HIV/AIDS related complications; prevention, diagnosis and treatment of Opportunistic Infections and STIs; management of HIV essential drugs; counseling and referral to community-based organizations; training on pain relief and management; risk reduction counseling; and referral to family planning services. Cross-cutting health system areas such as CD4 laboratory testing, supply chain, and training for HIV-related HCWs will be prioritized.

To link community and facility activities, PEPFAR will continue its key PAF-centered community outreach program which focuses on treatment retention strategies. For KP, PEPFAR will target “hot-spots” for testing as an effective case identification strategy and then ensure effective linkages through the continuum of community and clinic-based services. To facilitate retention and treatment adherence amongst KP a modified PAF model will be adapted with KP peer support.

4.7 TB/HIV

PEPFAR Angola will focus on intensified TB case finding among PLHIV in PEPFAR supported sites and will procure a GeneXpert in COP 14 to assist in scaling-up. This will support intensified TB case finding among PLHIV and identify first line TB treatment resistance. PEPFAR Angola will promote the implementation of integrated service delivery of TB and ART treatment, and revise protocols for TB infection control measures at ART sites. A focus on increasing TB screening among PLHIV will be emphasized as well as TB and HIV testing among persons diagnosed with HIV or TB, respectively.

Based on 2013 TB program data, 24,239 (39 percent) TB patients were tested for HIV, 2,667 (11 percent) of those tested for HIV were found to be HIV/TB co-infected. This increased from 26 percent in 2011. Approximately 20 percent of infections were in Luanda. From 2007 to 2013, the incidence of TB increased in Angola from 207 to 277 per 100,000. During the same time period, prevalence increased from 250 to 340 per 100,000 in 2013. No data is available on the proportion of TB co-infected patients who initiate ART. Limited data is available on the number of HIV co-infected patients who are currently on ART. There is an observed need for better TB infection control practices in public health ART clinics. PEPFAR Angola plans include increasing HIV testing among TB patients and developing models for better linkage to HIV care, treatment and follow-up services at two high burden facilities in Luanda. PEPFAR will work with the National TB Control Program to ensure that ART is initiated in all HIV+ TB patients regardless of CD4 status. PEPFAR will provide technical assistance and support in the nine sites for enhanced screening for active TB on intake and at each clinical visit for all HIV-infected patients. Each site will have a system in place to ensure TB diagnostic evaluation of patients suspected of having active TB, and provision of IPT to HIV-infected patients who screen negative for active TB per national guidelines.

4.8 Adult Treatment

The GRA estimates that in 2014, 30 percent of adults who initiated treatment were lost to follow up. PEPFAR Angola will focus on increasing initiation onto treatment by 40 percent of the existing gap to reach UNAIDS 90-90-90 in Luanda Province. PEPFAR will work with the GRA and clinic staff to improve ART data collection, quality, and use to better document treatment initiation, tracking, and ability to follow up with persons missing their care and treatment-related appointments through the implementation of SIS and the use of PAFs. The electronic longitudinal information system will track individuals through the continuum of care while PAFs will support active lost to follow up client tracing. Furthermore, PEPFAR will focus on laboratory support for CD4 to assess eligibility for ART and viral load testing as part of adherence monitoring. Implementing partners will provide training to clinicians on HIV clinical care and treatment and intense clinical mentoring for Angolan clinicians who are based in the model sites. Senior clinicians at the sites will be trained to mentor other clinicians. PEPFAR Angola will provide support for quality improvement methodologies based on facility performance to increase adult treatment, retention and adherence. In addition, PEPFAR will focus on cross-cutting support in laboratory strengthening (including improved linkage with clinics) and commodities/inventory management.

PEPFAR Angola will ensure timely access and continuity of medically appropriate levels of care and treatment for PLHIV through the implementation of a case manager system. Case managers are nurses or other highly trained clinicians who will monitor all PLHIV who enter into the health system. Case managers will assist with effective navigation of HIV care and treatment services within the selected clinical sites. The ultimate goal of case management is to ensure continuum of care which facilitates epidemic control. This is done by increasing the number of PLHIV receiving sustained antiretroviral therapy and subsequently having viral suppression.

Retention on treatment, once a person is entered in system, is particularly important in the cascade. Therefore, to integrate community and facility, PEPFAR Angola will implement community outreach through PAFs to optimize adherence and retention. The model sites will also enhance the use of existing peer support groups at the clinics and form community adherence groups in the clinic catchment areas. This effort will increase linkages for all PLHIV to care and treatment to reduce lost to follow-up. PEPFAR will provide technical assistance to develop a model of family-friendly services to reduce the current barriers for HIV exposed family members to receive testing and, if necessary, treatment in the same facility. PEPFAR Angola will document the implementation of proposed care and treatment models, including collaboration with above-sites and community institutions, for the effective transference to INLS for further scale-up.

The decision to focus on linkages among military personnel is aligned with PEPFAR's approach of reaching care and treatment saturation of the military's HIV+ population. USG support of HTC services and mobile campaigns will be directed at geographic and high risk military units or groups to achieve high yields and linkages to military care and treatment facilities.

Many HIV+ pregnant women do not start treatment and those that do are not retained after the first year. PEPFAR will provide enhanced technical assistance to increase the number of

women who test positive are started and retained on treatment after delivery. PEPFAR Angola will focus on the effective link between national PMTCT services to adult treatment and care services. Increasing the number of new mothers effectively using adult services after delivery will have an important impact on epidemic control.

4.9 Pediatric Treatment

Pediatric care and treatment will be addressed only in the context of the complete model of service cascade of care.

4.10 OVC

Not applicable to Angola.

Table 4.1.1 ART Targets in Scale-Up Districts for Epidemic Control

Angola	Total PLHIV	Expected current on ART (APR 2015)	Additional patients required for 80percent ART coverage	Target current on ART (APR 2016)	Newly initiated in FY 16
Luanda	82,441	6,121 initiated in 2014	60,656	17,417	5,310
Total					

Table 4.1.2 Target Populations for Newly Initiating ART Patients in Scale-Up Districts

Target Populations	
TB-HIV Patients not on ART	not utilizing TB_ART indicator this year; focusing on TB_SCREEN and TB_STAT year one, will incorporate TB_ART after situation is better understood
HIV-positive Pregnant Women	9,018 (19,187 nationally—Luanda with 47% burden)
Other priority and KP Military	338
Total	

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	
MSM 15-49	- 28,970
Female Sex workers	- 32,446
Other priority and KP Military	- 6500
Total	

5.0 Program Activities to Sustain Support for Other Locations and Populations

PEPFAR Angola has limited funding to support all GRA efforts and has made the strategic decision to concentrate in a few select, high-impact sites to provide intensive systems strengthening and quality improvement activities that can be replicated to eventually drive down the epidemic.

MINSAs does not have written protocols or guidelines for HIV care and treatment for the general population. MINSAs states that they work in an integrated primary care system. MINSAs offers life-time treatment regardless of CD4 count to all HIV positive: pregnant women, children <5 years old, adults >55 years old, and HIV+ individuals with renal or cardiac disease. This policy is outlined in MINSAs's "Acceleration Response". The GRA provides all resources to the HIV/AIDS response excluding those targeted, technical assistance resources provided by USG.

PEPFAR's transition of selected near-core and non-core technical assistance occurred in COP 14. The remaining near-core assistance of PPP and supply chain management will be transitioned in the next two years.

6.0 Cross-cutting Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

Quality of HIV and CD4 testing and a lack of VL testing to assess adherence and effectiveness of ART have been identified as bottlenecks in the continuum of care response. PEPFAR Angola will focus its core laboratory activities on:

- 1) Quality assurance programs for HIV rapid testing, CD4,
- 2) Training for laboratory technicians conducting rapid testing, CD4 testing, VL
- 3) Improved linkage between laboratories and clinics
- 4) Direct supervision to three national laboratories and nine POC
- 5) Support through SLMTA accreditation
- 6) Military laboratory quality assurance

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Training of laboratory technicians at the reference lab and improvement of linkage between clinical and laboratory services PEPFAR supported sites in Luanda.	Increased ability to perform viral load and CD4 testing resulting in overall improved quality. Improved linkages between clinical sites and lab resulting in faster return rate of results	Increased ability to perform viral load and CD4 testing resulting in overall improved quality.	HLAB	HLAB	17849	HRH 10.5	X	X	X		X
Conducting quality assurance visits for POC EQA for HIV testing and CD4	External quality assurance conducted a minimum of three times per year at nine sites.	External quality assurance conducted a minimum of three times per year at nine sites.	HLAB	HLAB	17849	QM 16.0	X	X	X		X
Support two HIV labs and one TB lab towards accreditation through SLMTA.	Progress towards earning no less than one star at the new labs (TB and one HIV). Continued progress at INLS lab.	Achievement of two stars at new HIV lab, one star at TB lab, and four stars/accreditation at present INLS labs.	HLAB	HLAB	17849	QM 16					X

Oversight VL at nine PEPFAR supported sites in Luanda.	Increased ability to perform VL at HIV care and treatment reference unit.	Increased ability to perform VL at HIV care and treatment reference unit.	HLAB	HLAB	17848	QM 16	X	X	X		X
Support four military laboratories at site providing ART for military populations		Increased ability to perform routine laboratory functions to support care and treatment services, and improved QA.	HLAB	HLAB	17397	QM 16	X	X	X		X
Purchase of GeneXpert to improve intensified TB-case finding in Luanda. Provision of training in appropriate use of GeneXpert improves TB diagnosis and linkage between HIV and TB services and TB clinics.	Increased capacity to diagnose TB in PLHIV in 9 sites and ability to identify 1 st line TB drug treatment resistance.	Improved TB case finding among PLHIV.	HVTB	HVTB	17849	HRH 10.5	X	X	X		X

Quality laboratory diagnostics is a critical component to facilitate accurate and early diagnosis of HIV, staging, identification of opportunistic infections and monitoring response to therapy. Laboratory infrastructure in Angola has not been able to keep up with the rapid scale-up of HIV diagnostic, care and treatment services. Confirmatory testing for HIV is only conducted at the National Blood Institute. The National Public Health Laboratory (INSP) is planning to resume confirmatory HIV testing later this year. Infrastructure and quality systems are especially lacking in public health primary clinics providing ART services. Access to rapid testing services is inadequate, access to CD4 testing (point-of-care or other) is variable and few clinics have access to routine viral load testing to assess adherence and effectiveness of ART. Given the increased demand for diagnostic services and gaps identified, PEPFAR Angola will focus on strengthening laboratory systems to ensure improved quality and increased accessibility to HIV-related laboratory services in the nine sites in Luanda. In the public clinics, PEPFAR will prioritize implementing CD4 and TB/HIV testing and quality assurance programs for rapid testing and point of care services. Twelve laboratory technicians will provide on-site in-service training, assessment and program monitoring, and technical assistance to support proper documentation, sample collection, and the establishment of a transportation network to and from clinics. At above-site level, mentors will continue to implement the competency-based laboratory accreditation program, Strengthening Laboratory Management toward Accreditation (SMLTA), in the INLS and INSP laboratories and will work with three labs on the accreditation process including the national HIV lab, the hospital based HIV reference lab and the National TB reference laboratory.

The DOD IP and the FAA will focus on the development and strengthening of laboratory networks and facilities to support HIV/AIDS related monitoring, and treatment services within the military's health structure.

6.2 Strategic information (SI)

Quality data to inform decision making for epidemic control is a core priority for PEPFAR Angola. Data quality has been poor, however baseline assessments are planned to begin in July 2015 to assist in understanding of how data can be improved and what areas PEPFAR can best focus efforts for optimal improvement. PEPFAR Angola will focus its SI activities on:

- 1) Implementation of Electronic Longitudinal information systems in select nine healthcare facilities and above levels, to improve data availability and use to be able to better report on indicators pertaining to the cascade of care including commodities forecasting.
- 2) Population-based survey on HIV through a DHS+
- 3) Biological and Behavioral Surveillance (BBS) surveys for KP to complete HIV stage setting in Angola.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Adapt and implement quality assessment to monitor the quality of HIV data in HIV care settings.	Assessment tool completed and implemented	Continued use of tool	HVSI	HVSI	17850	Quality management 16.0	X	X			X
Coordination of clinical and support staff trainings pertaining to quality improvement in data capture management, and use.	Three week short course on basic epidemiology (including data collection and use) for provincial public health clinicians.	Increased knowledge in and ability of provincial HIV clinicians and support staff in data collection, use, and management. (multiple provinces)	HVSI	HVSI	17851	HRH 10.5	X	X			
Evaluation of HIV data quality and other TBD M&E activities as agreed upon between INLS and PEPFAR priorities.	Planning and protocol development	Evaluation activity	HVSI	HVSI	17848	Quality management 16.0	X	X	X		X
Implementation of a national population-based survey (DHS+). <i>Will start in 2014</i>	Survey Initiated	Survey completed and final report distributed and published.	NA		ICF International	Epidemiological and Health data 10.6	X				

Design and Implementation of population-size estimations for KP in Luanda, Cunene, Bie and Benguela. <i>Will start in COP14</i>	Studies designed and initiated	Study completed, final report distributed, and results are used on service planning.	HVSI	HVSI	17308	Epidemiological and Health data 10.6	X					
Design and Implementation of Integrated Biological and Behavioral Surveillance (IBBS) Surveys, implemented in Cunene, Bie and Benguela.	IBBS survey completed in Luanda and final report distributed and published	IBBS completed in Cunene, Bie and Benguela. Study results are used on service planning by national and sub-national organizations.	HVSI	HVSI	17308	Epidemiological and Health data 10.6	X	X			X	
On-site training, mentorship, and direct supervision to health facility staff on the use of clinical records on a daily basis and conduct routine supervisions. Case Managers will ensure the appropriate use of standard data collection tools and effective use of clinical files. Technical assistance and mentor 9 high-yield facilities and above-sites to use available data – gathered and provided on a timely basis by other IM - for managerial and clinical decision-making.	Nine health care facilities, in Luanda, with staff trained on data collection, entry analysis, use, and reporting based on HIV continuum. National HIV program and municipalities have optimized their information integration and data flow.	Nine health care facilities in Luanda have fully implemented clinical records at the model sites. New sites/regions with staff trained on clinical data collection, analysis, use, and reporting based on HIV continuum.		HVSI HTXS HBHC	13559							

<p>Technical assistance at the facilities' pharmacies to implement HIV Drug Resistance Early Warning Indicators (EWIs); track ART patient's retention and transferences.</p>	<p>Nine pharmacies in Luanda with improved capacities to track patient retention and transference.</p> <p>Nine health care facilities implementing EWIs.</p>	<p>Nine pharmacies in Luanda has initiated their activities are model pharmacies for patient tracking and EWIs.</p> <p>New sites/regions with improved capacities to track patient retention and transference.</p>		OHSS	13607						
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SI is a core activity under Angola's framework. Based on the challenges of limited quality data for effective decision-making and weak health systems, PEPFAR Angola decided to increase activities and budget for SI. PEPFAR Angola will implement a model electronic longitudinal information system at the facility level to effectively track continuum of care activities at nine high-yield clinical sites in Luanda. PEPFAR will provide technical assistance and supervision to supported sites to gradually migrate from paper-based to an electronic information system. PEPFAR Angola will provide on-site training, mentorship, and direct supervision to facility staff on data collection, entry, analysis, use, and reporting. PEPFAR will assist each target facility to use programmatic and survey data available to identify trends, gaps and opportunities within the HIV continuum of care, and to incorporate improvement plans into planning and budgeting procedures within the facility and municipal framework. To ensure the effectiveness of the facility-level information system for decision making, PEPFAR will provide limited but high-intensity technical assistance to municipal systems to optimize the link among health sector levels and improve information flow for planning and budgeting.

PEPFAR Angola will implement with the GRA the first ever DHS+ starting in COP 14 and finalizing in FY 2016. MINSA and the National Statistics Institute are heavily involved with the implementing partner to insure that the survey starts before FY 2016. There will also be implementation of BBS surveys in Cunene, Bie and Benguela—complementing a COP 14 BBS in Luanda province. For PEPFAR, these results will be important to inform future technical assistance. There is limited accurate and credible data at this time to inform decision-making about HIV/AIDS. Good data will allow both the GRA and PEPFAR to use funding effectively and drive the epidemic down.

PEPFAR's DOD IP and the FAA will use COP15 funding to initiate the development of a military specific policy guidance document for HIV/AIDS in the military medical sites. This would be a guidance document for the military, and in the future would become the HIV policy. This policy/guidance will address access to services, HIV/AIDS and STI treatment, employment assurance, HTC regulations, confidentiality, and deployments for military personnel, and their families. This policy will reduce stigma and discrimination among military personnel, and enhance access and use of military health services.

6.3 Health System Strengthening (HSS)

Strong health systems are essential to a sustainable epidemic control. PEPFAR Angola will focus its HSS activities on:

- 1) Creation of models of service to demonstrate high quality replicable HIV care and treatment, and associated data.
- 2) Intense mentoring of clinicians and nurses to improve quality of HIV care and treatment in selected facilities in Luanda.
- 3) Technical assistance to improve commodity security and supply chain.
- 4) Technical assistance for systems strengthening at central, provincial and municipal levels

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Support training for public health professionals	Coordination of trainings and short courses on HIV for public health clinicians including HIV C&T, 3-week basic epidemiology course and training on methodologies for KP studies .	Coordination of trainings and short courses for public health clinicians.	HVSI	HVSI	17851	HRH 10.5	X	X			
Enhanced Technical Assistance, mentoring activities, and supervision to high-yield facilities of Luanda to create a model of clinical services through the continuum of care. Case management to ensure PLHIV access	Nine health facilities with complete baselines analysis and improvement plans for enhanced C&T services.	Nine health facilities with case managers and on-site mentors, providing support and direct supervision for clinical services	HTXS HBHC	OHSS HTXS HBHC	13559	Quality management 17.0	X	X	X		X

services among the continuum of care. In addition, case managers effectively link health facilities providing antiretroviral therapy with community resources providing additional services and support to HIV+											
Implement quality assessment tool -Standard-based Management and Recognition (SBMR) - to monitor the quality of HIV/AIDS services. This strategy includes the develop of SRMS supervision plan to support QI services at the health facilities	Nine health facilities with at least 2 rounds of SBMR and implementing improvement plans	Nine health facilities with at least 2 rounds of SBMR and implementing improvement plans	OHSS HTXS HBHC HVCT	OHSS HTXS HBHC HVCT	13559	Quality management 17.0	X	X	X		X
Develop a military specific policy/guidance address access to services, HIV/AIDS and STI treatment,		Development and validation of the policy document for dissemination.	OHSS	OHSS	17397		X	X	X		X

employment assurance, HTC regulations, confidentiality, and deployments for military personnel, and their families. This policy will reduce stigma and discrimination among military personnel, and enhance access to services.												
Technical assistance to nine selected high-yield facilities to improve commodity security and supply chain	Nine high-yield facilities with baseline analysis on commodity security and supply chain	Manuals and guidelines designed for both adults and children. Pharmaceutical management tools implemented in Nine facilities to avoid stock-outs A national distribution system designed based on orders from health facilities	OHSS	OHSS	13607	Commodity Security and Supply Chain 15	X	X	X			
Technical assistance to municipal institution on planning and budgeting, as well as	Luanda municipalities completing district budgeting process	Three municipalities in Luanda with approved 2016 budgeted plan to implement activities in high-	OHSS	OHSS	13559	Planning and coordination 14	X	X	X	X	X	

supervisory procedures to effectively implement HIV/AIDS activities in selected high-yield facilities.		yield facilities										
Technical assistance to strengthen capacity of local organizations focusing on KP	At least two selected CSOs in Luanda received training on technical and management	At least two selected CSOs in Luanda with strengthen organizational performance and competency to close leaks in the HIV cascade.	HVOP	HVOP	17308	Planning and coordination 14	X	X	X			
Improve 17306 Governance and Institutional Capacity	Members trained in managerial and technical procedures	improved managerial and technical capacities to work against HIV/AIDS	OHSS	OHSS	TBD	Planning and coordination 14	X	X				

* N = National, SN = sub-national; S = site/facility

Without an effective supply chain and rational use of HIV/AIDS commodities for diagnosis, treatment and prevention; creating an AIDS free generation will remain a challenge. PEPFAR Angola is redirecting its technical assistance to focus on nine high-yield facilities in Luanda to design and implement an improved HIV/AIDS pharmaceutical management model for future replication and scale-up nationwide. To increase sustainability, PEPFAR will also provide limited but specific technical assistance to local level governance and warehouse to ensure supply chain among selected high-yield facilities. PEPFAR support will focus on: 1) forecasting and supply planning using patient regimen patterns, morbidity data, past consumption and new targets; 2) preparing quarterly requisitions base on stock monitoring; 3) developing optimal storage and distribution strategies; 4) promoting rational use of ARTs and best dispensing practices –including the development of guidelines and the distribution of existing stock of past procurement to facilitate the transition to new regimens avoiding waste of valuable resources; 5) providing tools for patient counselling and tracking patient adherence at pharmacy level –as part of the USG strategy to improve patient retention; 6) promoting the reduction on the number for ARV treatment regimens to simplify procurement and supply chain logistics; and 6) monitoring supplies and reordering procedures.

Using the Standard-based Management and Recognition (SBMR) approach, PEPFAR will support nine selected facilities with a sustainable strategy to identify HIV performance gaps and design and implement HIV action plans to bridge them. In addition, PEPFAR will design and implement practical tools to complete planning and budgeting procedures for the effective and sustainable implementation of HIV/AIDS activities in the selected high-yield facilities.

PEPFAR Angola will support a PPP as a key strategy for HIV/AIDS program sustainability. The focus will be on the provision of technical assistance to Angola's committee of private companies working against HIV/AIDS. PEPFAR Angola will provide assistance to improve governance structure and institutional capacity for internal organization, financial management, HIV program design, and monitoring and evaluation. PEPFAR support will facilitate Angola's efforts to mobilize other companies to promote workforce well-being and corporate social responsibility.

7.0 Staffing Plan

PEPFAR Angola reviewed each of the 18 positions approved in COP14 (State – 1, CDC – 11, DOD – 1 and USAID – 5) vis-à-vis the program pivots, specifically the increased focus on core activities (Strategic Information, KP, Care and Treatment, PMTCT and Laboratory); the gradual transition away from near core activities (Commodities Security and Public Private Partnerships); and the phase out of non-core activities (Social Marketing, Finance, FELTP, Blood Safety). Therefore, COP 15 has been reduced to 15 staff. In addition, there will be two non-PEPFAR funded USAID direct hires that devote significant time to helping the mission meet PEPFAR goals.

CDC has requested to repurpose/realign the following positions:

- 1) Combine the two vacant Public Health Specialist positions (Surveillance and M&E) into one M&E/Surveillance position. The position would be supervised by the SI Advisor and lead M&E efforts for CDC Angola and assist in PEPFAR through M&E-related reporting. Large surveillance projects are sporadic in the PEPFAR Angola program, by combining the two positions the incumbent could focus primarily on M&E projects while supporting surveillance as needed.
- 2) With the increased focus on care and treatment under the PEPFAR Angola program post-pivot, it has become evident that a staff member with increased knowledge of HIV care and treatment issues is necessary. CDC would like to use the additional Public Health Specialist opening (created through proposal one above) to create a Public Health Specialist-Care and Treatment position. This person would lead CDC's efforts in working with the care and treatment IP and monitoring Care and Treatment-related work (training, evaluation, and quality improvement).
- 3) CDC is requesting to repurpose one driver position to a clerical position with part-time driving responsibilities. It is estimated that the incumbent would spend 60% of their time on clerical related duties including basic data entry and 40% of their time as a driver.

The total staff size for CDC overall will decrease between COP14 and COP15. In COP15 (including position requests above), CDC Angola will have eight positions.

All PEPFAR-funded staff, along with three non-PEPFAR funded staff participates in SIMS reviews.

Technical assistance will not be delivered exclusively through implementing partners. USG staff will increasingly offer direct support for strategic information, care and treatment quality, and laboratory diagnostics.

The following chart shows the Angola PEPFAR staffing support (vacant in highlight)

	Status	Position	Agency	Category	Primary Focus
1.	Filled	PEPFAR Coordinator	State	USPSC	General Support
2.	Filled	HIV Program Manager	DOD	FSN	SI, C/T, Prevention (Core)
3.	Filled	Country Director	CDC	USDH	Strategic Information (Core) Care and Treatment (Core) Laboratory (Core)
4.	Filled	Epidemiologist	CDC	USDH	Strategic Information (Core)
5.	Filled	Senior Lab Advisor	CDC	FSN	Laboratory (Core)
6.	Vacant	Public Health Specialist – Surveillance/M&E	CDC	FSN	Strategic Information (Core)
7.	Filled	Cooperative Agreement Manager/Budget Analyst	CDC	FSN	General Support
8.	Filled	HIV Program Specialist (Executive Admin Support)	CDC	FSN	General Support Strategic Information
9.	Vacant	Public Health Specialist Care and Treatment	CDC	FSN	Care and Treatment

10	Filled	Data clerk/driver	CDC	FSN	General Support
11	Filled	Senior HIV Advisor	USAID	TCN PSC	Strategic Information (Core) Care and Treatment (Core) PMTCT (Core)
12	Filled	HIV Specialist	USAID	FSN	Strategic Information (Core) KP and Stigma and Discrimination (Core)
13	Filled	Health Systems Specialist	USAID	FSN	Commodities Security (Near Core)
14	Filled	Program Budget Specialist	USAID	FSN	General Support
15	Vacant	M&E Specialist	USAID	FSN	General Support

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	SI, C/T, Lab, stigma	Commodities security	
Sub-national level	SI, Lab	Commodities security	
National level	SI, Lab	Commodities security, PPP	FELTP, PMTCT, EID

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

HTC	Targeted HTC, link to C/T		
Care and Treatment Prevention	Initiation of new patients, support groups		
HSS	PHDP		
KP	Lab strengthening, commodities linkages		
Priority Population	Prevention education		
SI	DHS+, KP size estimation, BBS		
Totals			

APPENDIX B

B.1 Planned Spending in 2016

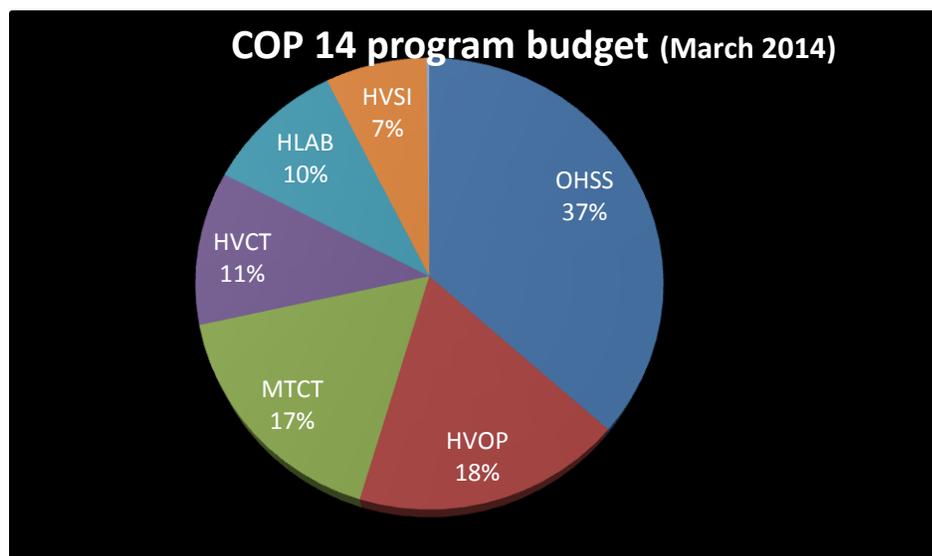
Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$1,470,000	\$16,230,000	\$17,700,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
HVOP	Other Sexual Prevention	\$359,375
HVCT	Counseling and Testing	\$1,140,562
HBHC	Adult Care and Support	\$2,707,422
HTXS	Adult Treatment	\$2,019,617
HLAB	Lab	\$1,703,004
HVSI	Strategic Information	\$2,832,161
OHSS	Health Systems Strengthening	\$1,743,697
HVTB	HIV/TB	\$310,285
HVMS	Management and Operations	\$3,403,806
HVAB	Abstinence and Be Faithful	\$10,071
TOTAL		16,230,000

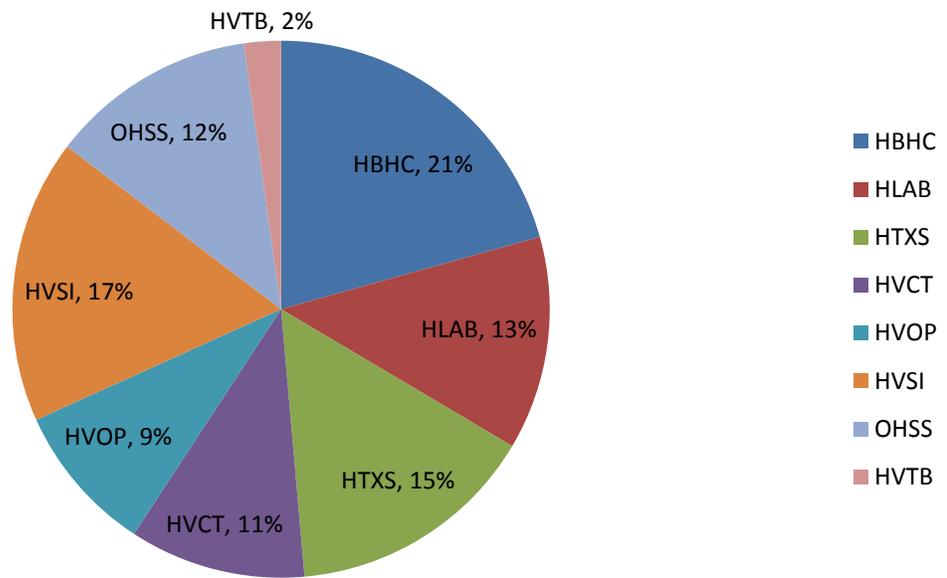
B.2 Resource Projections

Data sources included Spectrum projections completed in February 2015, ANC 2013 data, INLS-provided HIV testing and treatment figures, and GRA-provided TB estimates.

The charts below show the shift of budgeted funding from COP 14 to COP 15. The refocus to SI is apparent with over double the percentage of planned funding. The COP 14 budget did not have care and treatment funding which is reflected in the re-focused COP 15 programming.



COP 15 program budget



Angola COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Bengo	-	-	-	-	-
Benguela	-	-	-	-	-
Bié	-	-	-	-	-
Cabinda	-	-	-	-	-
Cunene	-	-	-	-	-
Huambo	-	-	-	-	-
Huíla	-	-	-	-	-
Kuando Kubango	-	-	-	-	-
Kwanza Norte	-	-	-	-	-
Kwanza Sul	-	-	-	-	-
Luanda	80,005	6,275	24,140	-	17,417
Lunda Norte	-	-	-	-	-
Lunda Sul	-	-	-	-	-
Malanje	-	-	-	-	-
Moxico	-	-	-	-	-
Namibe	-	-	-	-	-
Uíge	-	-	-	-	-
Zaire	-	-	-	-	-
Other_ Angola	15,000	750	-	-	-
Total	95,005	7,025	24,140	-	17,417

Angola COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Bengo	-	-	-
Benguela	-	-	-
Bié	-	-	-
Cabinda	-	-	-
Cunene	-	-	-
Huambo	-	-	-
Huíla	-	-	-
Kuando Kubango	-	-	-
Kwanza Norte	-	-	-
Kwanza Sul	-	-	-
Luanda	-	16,500	-
Lunda Norte	-	-	-
Lunda Sul	-	-	-
Malanje	-	-	-
Moxico	-	-	-
Namibe	-	-	-
Uíge	-	-	-
Zaire	-	-	-
Other_ Angola	6,500	-	-
Total	6,500	16,500	-