

Country Operational Plan

COP2016

Strategic Direction Summary

PEPFAR Angola

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Goal Statement

The overarching goal of PEPFAR Angola is to improve services in order to deliver on the promise of an AIDS-Free generation.

In COP16, PEPFAR Angola will continue to work in nine select HIV testing and counseling (HTC) high-volume clinics, and in communities within high-prevalence areas of Luanda, to develop models of HIV/AIDS interventions that the country can replicate elsewhere and expand to a greater scale. To achieve epidemic control, substantially greater efforts will be made to: 1) advance strategic information and systems to deliver HIV care and treatment (C&T); 2) improve linkage and access to high quality C&T services for people living with HIV (PLHIV) and 3) support the implementation of viral load (VL) systems to monitor adherence and viral suppression.

The first step in achieving epidemic control is to better understand the epidemic. In 2015, PEPFAR Angola partnered with the Government of the Republic of Angola (GRA) to complete the first-ever nationwide demographic household survey with bio-markers (DHS+). In COP16, information from the analysis of DHS+ will be used to refine activities and evaluate opportunities for interventions in other geographic areas. In COP16, PEPFAR Angola will also have results from the Integrated Biological and Behavioral Surveillance (IBBS) surveys among key populations (KPs). This will allow better understanding of the epidemic among these groups. PEPFAR will continue to support the implementation of a longitudinal monitoring and evaluation (M&E) system at the facility level to effectively track the continuum of care and optimize data flow and communication between health sector levels.

The second step in achieving epidemic control is to improve and expand high quality treatment services for PLHIV. PEPFAR Angola will lay the groundwork for Test and Start in COP16. In order to ensure that overburdened health facilities are able to accommodate and start all patients on antiretroviral therapy (ART), systems of care must be developed and differentiated models implemented. Patient flow and patient visit schedules will be modified to allow greater access. Health care workers (HCWs) will have more time to provide better quality of care for patients newly enrolled on treatment, leading to efficiency gains and overall improvements in treatment adherence. In each of these areas, PEPFAR Angola will support the GRA with technical support in COP16.

PEPFAR Angola is optimistic, as a result of promising dialogue and action with the GRA, that new leadership at the Ministry of Health will support efforts to initiate and scale-up Test and Start. Military leadership has indicated that they will support Test and Start at all their treatment sites this year. We already have a commitment from the National AIDS Institute (INLS) to implement Test and Start for all KPs. The challenge to Test and Start is overcoming the concerns around the immediate financial impact of increasing the number of people on antiretroviral drugs (ARVs) in a time of serious financial crisis for the country.

To track performance in real-time, PEPFAR Angola will meet monthly with implementing partners and clinic staff to review data and monitor achievement of targets. PEPFAR Angola will

also meet monthly with INLS and Luanda Provincial Health Directorate (DPS) to build a culture of monitoring, evaluating, and using data for decision-making.

PEPFAR Angola will contribute to epidemic control through increasing understanding of the HIV epidemic in the country, improving C&T systems, supporting VL scale-up, and advocating for national adoption of Test and Start.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country profile

Angola has an estimated population of 25,789,024 inhabitants (2016 National Census data). It is a middle income country with a Gross National Income (GNI) per capita of \$6,822 (World Bank 2014). In the past year, Angola's once booming economy has been adversely affected by the worldwide drop in oil prices. The HIV/AIDS epidemic in Angola is a low-level generalized heterosexually-driven HIV/AIDS epidemic.

There are limited population-based HIV surveillance data. A DHS+ was conducted in 2015. It included HIV sero-prevalence testing data. This information is expected to be available later in 2016 and will be used to inform planning for COP17. HIV interventions to date 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).

Table 1.1.1 shows key national epidemiologic and demographic data for Angola. In 2014, HIV prevalence in the general population was estimated to be 2.42% in adults aged 15-49, with an estimated 300,000 persons, including 30,000 children, living with HIV/AIDS (Spectrum 2014). Prevalence among adult females (15-49 years of age) continues to be higher than among adult males (2.8% vs 2.0%). Prevalence among young adults age 15-24 years is relatively low; it is higher among females than males (1.2% in females and 0.64% in males). HIV incidence has increased from 0.24% in 2004 to 0.28% in 2014 among adults 15 -49 years of age. The estimated annual number of new infections in Angola has been more than the estimated annual number of AIDS-related deaths since 2004. Mother to child transmission rates have decreased from an estimated (Spectrum) 40.8% in 2004, to 37.5% in 2012, and to 25.2% in 2014.

HIV prevalence among Angola's 100,000 Armed Forces was estimated at 2.5% in the 2015 Seroprevalence and Behavioral Epidemiological Risk Survey (SABERS). [REDACTED]. The DOD identifies military personnel as a priority population for HIV interventions.

ANC sero-prevalence surveys have been conducted since 2005 in Angola; since this time, HIV prevalence among pregnant women has been stable at 2%-3%. The 2013 ANC sero-prevalence survey showed an overall HIV prevalence of 2.24%, and a rate of 1.7% among 15-24 years old women. HIV prevalence is not evenly distributed throughout the country. In 2013, ANC HIV

prevalence exceeded 4% in five of 18 provinces (Benguela, Bie, Cunene, Cuando Cubongo, Lunde Norte). HIV prevalence among pregnant women living in urban areas was higher (2.6%) compared to those living in rural areas (2%). In Luanda, the ANC prevalence was estimated at 3% based on the median HIV ANC prevalence of the eight clinics participating in the biennial ANC HIV sentinel surveillance from 2009-2013.

Angola is among the 22 high tuberculosis (TB) burden countries in the world and one of the countries with highest TB burden in Africa. In 2013, of the 60,807 registered cases of TB, 24,445 TB patients were tested for HIV, corresponding to 40.2% of patients registered with TB. Of these, 2,674 were HIV (+), equivalent to a positive rate of 12.8%. In 2014, there were 56,716 registered cases of TB in Angola, 27,699 people with TB were tested for HIV, and 2,827 were positive which is equivalent to a 10.2% positive rate. In Luanda, there were 21,986 registered cases of TB in 2014, 10,109 (45%) were tested for HIV; 1,799 were HIV+ which represents an 18% positive TB/HIV co-infection rate.

KP size estimates are based on global peer-reviewed literature (2.0 percent men who have sex with men (MSM) and 2.2 percent female sex worker (FSW). 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.

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.

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	19794052	100	4615573	23.3	4671074	23.6	4466188	22.5	4388046	22.1	UNAIDS Spectrum 2014
Prevalence (%)15-49		2.42		NA		NA		2.84		2	Spectrum 2014
AIDS Deaths (2014)	8053		761		749		3371		3172		Spectrum 2014
PLHIV	300000		14850		15150		160000		110000		Spectrum 2014
Incidence (15-49) (2014)		0.28		NA		NA		0.30		0.22	Spectrum 2014
New Infections (2014)	26000										Spectrum 2014
Annual births	950122										Nat'l Reprod. Prog. Final Report, 2013

% >= 1 ANC visit	649,594	68.45	NA	--			NA	--			Nat'l Reprod. Prog. Final Report, 2013
Pregnant women needing ARVs	19182	45.4									Spectrum 2014
Orphans (maternal, paternal, double)	115549		NA		NA		NA		NA		Spectrum 2014
TB cases (2013)	60,807		500		300		25,648		34,359		GRA TB Report-2013
TB/HIV Co-infection	2,827	10.2*	NA	--	NA	--	NA	--	NA	--	GRA TB Report-2014 *27699 (tested/HIV). Co-infection rate outside Luanda is estimated at 5%; rate in Luanda is 18%
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	-										
Total FSW	124,540	2.2									Vandepitte 2006 (Est Africa)
FSW HIV Prevalence											UNAIDS 2008, Angola
Total PWID	---	---									
PWID HIV Prevalence	---	---									
Priority Populations Military	100000	2.5%									SABERS 2015

*The Angolan National Statistic Bureau estimated the total population at 19794052 in 2014. This number was used for Spectrum 2014 estimates. 2016 population estimates are significantly higher with the release of the new census data in March 2016.

**TB/HIV The overall TB/HIV co-infection rate for Angola was estimated at 10.2% in 2014 (outside Luanda is estimated at 5%; rate in Luanda is 18%)

In 2014, National AIDS (INLS) program data show there were an estimated 45,719 newly reported HIV infections and 4,659 AIDS deaths in 2014. Of the estimated 45,719 newly reported HIV infections that occurred in 2014, 91% were reported in adults; 9% occurred in children <15 years of age. Table 1.1.2 (below) shows the cascade of HIV diagnosis, care and treatment in Angola and in the province of Luanda, where the nine model sites are located in 2014. In 2014, INLS program

data reported 1,204,866 HIV tests were conducted in Angola, 3.8% were positive (45,719) and 39% (17,769) of those newly identified HIV-infected received antiretroviral therapy; 573,490 adults were tested, 5.4% (31,078) were positive and 53% (16,468) were initiated on ART compared to 79,986 children <15 tested and 4.9% (3,970) positive and 33% (1301) were initiated on ART.

In 2014, approximately two-thirds of the estimated 950,122 pregnant women utilized public clinics. A total of 564,971 tests for HIV were conducted, 1.9% of tests were HIV positive, and 83% of the identified HIV-infected pregnant women in Angola received antiretroviral drugs.

A total of 251,070 HIV tests were conducted in Luanda in 2014; 7% were positive. Yield was highest in children (16%) <15 years, and adults (11%) >15 years of age, and lowest in pregnant women 2.8%. Of those identified as HIV positive in Luanda, 26% of children and 52% of adults were initiated on ART. In 2014, 88% of the identified HIV-infected pregnant women in Luanda received antiretroviral drugs.

There is no National AIDS Program data available for key populations (sex workers and MSM, among others). To date, two HIV prevalence studies have been completed - a 2011 MSM IBBS in Luanda Province and a 2011 IBBS among women engaged in transactional sex in Cunene Province. Both were limited in geographic focus and results from both have been critiqued. KP data estimates remain unclear, as data has not been updated since the aforementioned studies. However, a KP IBBS survey will be completed in FY16 to update this information. Also, the Southern African Development Community (SADC) has recently completed a respondent driven survey (RDS) among sex workers in Luanda. Analysis of this study is expected to be made available in the coming months.

HIV prevalence among the 100,000 Angolan Armed Forces was estimated at 2.5% in the 2015 SABERs HIV Prevalence Survey. In 2015, 16,519 military were tested for HIV, 357 were identified as HIV positive and 116 were linked to treatment.

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months) 2014

				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	Total on ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population Angola	19794052	2.42	300,000	68507	-	-	1204866	45719	17769
Population less than 15 years Angola	10675837	-	30000	4674	-	-	79986	3970	1301
Pregnant Women Angola	950122	ANC 2.24%	Included in gen pop total	8827	-	-	551390	10671	8827
Population 15-49 Luanda	2,915442	2.83	82441	28153	12960**	-	109249	11638	6106
Population less than 15 Luanda	3074694	-	9119	2908	960*	-	16319	2602	683
Pregnant Women Luanda	310979	3%	9329	5556	2556**	-	125502	3596	3154
MSM	6,236***	3.7% ***	-	-	-	-	333	5	2
FSW	-	8.5%	-	-	-	-	1655	56	11
PWID	-	-	-	-	-	-	-	-	-
Military	100,000	2.5%	2,500	-	-	-	16519	357	116

* 33% Estimate based on INLS data for retention of PLHIV < 15 years

** 46% estimate based on baseline data from all 9 sites.

*** Kendall et al, Population size, HIV, and behavior among MSM in Luanda, Angola: challenges and findings in the first ever HIV and syphilis biological and behavioral survey. 2011

1.2 Investment Profile

Although Angola was classified as a medium-high income country in 2012, the economy remains heavily dependent on the oil sector and is vulnerable to global market fluctuations. The oil industry accounts for approximately 50% of GDP and 75% of government revenues. Oil and related products account for 97% of Angola's exports. Due to the decline of oil prices internationally, estimated Angolan revenue fell from \$39 billion to \$25 billion, while gross expenditures fell from \$48.7 billion to \$32.7 billion in the revised 2015 budget. This macroeconomic and revenue environment has led the GRA to reduce in-country spending, and to prioritize government operational and defense spending over social sectors. Consequently, Angola faces significant challenges to achieving epidemic control due to a decrease in revenue, lack of essential medicines, stock outs, delayed payment of salaries, and lack of investment in equipment and infrastructure.

If macroeconomic instability continues, the national HIV/AIDS program could be compromised, as budgets shrink further. Increased linkages of PLHIV to care, treatment, and other HIV/AIDS services could strain the reduced national budget. 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 the continuing downward trend of external donor investment in Angola. Additionally, recent concurrent Yellow Fever and Malaria epidemics have placed severe additional strains on the country's health system. It is worth noting that in the midst of a bleak funding horizon, the GRA has had some degree of success at mobilizing resources from the private sector.

Despite these challenges, the HIV/AIDS response has largely been financed by domestic resources. PEPFAR Angola is the only donor entity, at this time, which substantially supports the Angolan HIV/AIDS response.

Table 1.2.1 Investment Profile by Program Area

Program area	Total	% PEPFAR*	% GF**	%GRA
Clinical care, treatment and support	\$32,365,247	13%	40%	47%
Community-based care, treatment, and support	\$3,081,830	0%	3%	97%
PMTCT	\$2,302,076	0%	13%	87%
HTS	\$5,456,755	42%	8%	51%
VMMC	-	-	-	-
Priority population prevention	\$2,361,982	0%	51%	49%
Key population prevention	\$6,255,613	23%	9%	67%
OVC	-	-	-	-
Laboratory	\$2,354,974	40%	5%	56%
SI, Surveys and Surveillance	\$4,074,081	36%	0%	64%
HSS	\$3,047,309	75%	0%	25%
Total	\$61,299,868	\$12,676,358	\$15,630,142	\$32,993,367
*PEPFAR excludes \$5M program management costs				
**GF excludes \$2.2M program management costs				

Table 1.2.2 Procurement Profile for Key Commodities (FY17)

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	-	0	40	60	-
Rapid test kits	-	0	40	60	-
Other drugs	-	0	-	100	-
Lab reagents	-	0	-	100	-
Condoms	-	0	-	100	-
Viral Load commodities	-	0	-	100	-
VMMC kits	-	0	-	100	-
MAT	-	0	-	100	-
Other commodities	-	0	-	100	-
Total	-	0	-	-	-

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
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USAID MCH	\$1,000,000	-	-	-
USAID TB	0	-	-	-
USAID Malaria	\$29,000,000	-	-	-
Family Planning	0	-	-	-
NIH	0	-	-	-
CDC NCD	0	-	-	-
Peace Corps	0	-	-	-
DOD Ebola	0	-	-	-
MCC	0	-	-	-
Total	\$30,000,000	-	-	-

1.3 National Sustainability Profile

For COP16, PEPFAR Angola, UNAIDS, and INLS worked together to define approaches and implement the Sustainability Index and Dashboard (SID). The PEPFAR-UNAIDS-INLS team facilitated two separate workshops. Stage one occurred in March with MOH and INLS technical teams. Stage Two occurred in May and added participants from civil society, private sector, Luanda Provincial Health, the Armed Forces, and Prison Services. Implementing in two phases helped progressive understanding of the use of the tool to assess the country’s HIV programmatic sustainability. Through the SID, PEPFAR Angola is strengthening the capacity of stakeholders to track progress towards sustainability over time and continued in-depth analysis to identify barriers to sustainability.

Elements within the “Governance, Leadership, and Accountability,” “Strategic Investments, Efficiency, and Sustainable Financing,” and “Strategic Information” domains indicated results consistent with sustainability and will require limited investment from stakeholders and multilateral partners. However, other elements within these domains, such as “Civil Society Engagement,” “Domestic Resource Mobilization,” “Commodity Security and Supply Chain,” and “Epidemiological and Performance Data,” indicated emerging sustainability issues that will require initiatives to promote the engagement of partners. PEPFAR Angola has included initiatives in COP6 to increase the sustainability levels in these elements through the engagement of partners, community stakeholders, and the GRA.

For example, PEPFAR Angola will provide technical assistance (TA) and training throughout the entire HIV care cascade to address “Quality Management” of HIV services. In the COP15 pivot, quality improvement (QI) efforts began with the implementation of the Site Improvement Monitoring System (SIMS) facility-based assessments and individualized improvement plans. PEPFAR Angola will develop a team of local Angolan mentors and health officers who will learn and apply QI methods and tools to develop a national QI system for HIV, improve health outcomes, and measure performance. To address other emerging sustainability issues, PEPFAR Angola will provide a number of activities such as DHS+ analysis and dissemination, implementing an electronic data management system as well as supporting HIV supply chains

and civil society engagement. These activities will be further addressed in continuing discussions about the SID with national counterparts on or before May 2016.

Elements such as “Private Sector Engagement” and “Quality Management” also appeared unsustainable and in need of attention. Both elements are directly related to the current economic crisis in Angola. The global drop in oil prices has impacted all sectors of Angola’s economy due to the country’s dependence on revenues from the oil industry, as noted above. Specifically, private companies have reduced social sector spending, including funding for HIV programs, due to the crisis. The GRA health budget has also suffered cuts which affect its ability to implement a systematic platform to improve the quality of existing healthcare services.

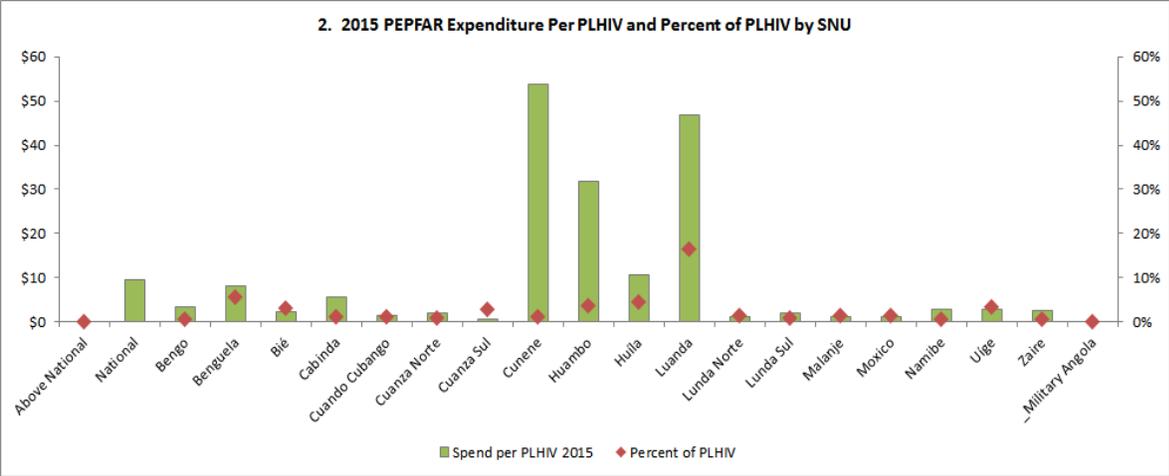
Addressing “Private Sector Engagement” will be very challenging during COP16 due to competing demands for corporate social responsibility spending at a time when the economy is so constricted. Despite the challenges, PEPFAR Angola has begun building partnerships related to current priorities and has found initial interest among pharmaceutical companies. To engage such stakeholders, PEPFAR Angola plans to partner with other international cooperation initiatives (e.g. PMI) to explore Public Private Partnership (PPP) opportunities to improve the availability of essential drugs and supplies in Angola.

1.4 Alignment of PEPFAR investments geographically to burden of disease

Based on MOH programmatic information and 2013 ANC sentinel surveillance, PEPFAR Angola identified Luanda Province as the most affected province during COP15. PEPFAR Angola has chosen to continue to focus HIV activities in Luanda Province during COP16 due to: higher burden of PLHIV and estimated higher number of KPs; limited funding and the high overall costs of doing business in Angola, and increased accessibility for implementing partners and U.S. Government (USG). PEPFAR Angola will design, implement, and document models of service provision among key populations, adults, and children at nine selected clinical facilities. Successful components of the model of service will be transferred to the GRA within a three year period so that the GRA can expand to other high volume sites outside Luanda.

PEPFAR Angola will complete HIV prevalence and size estimations as results are released from DHS+ and IBBS among key populations in Luanda, Bie, Benguela and Cunene by the end of FY16. These population-based HIV data will guide program decisions for COP17.

Figure 1.4.1 below is based on expenditure analysis for 2015. It shows that the highest burden of PLHIV is in Luanda and provides additional justification for the pivot in COP15 to focus on Luanda municipalities. It shows that expenditures per person living with HIV were highest in Cunene, followed by Luanda and Huambo. Other Angolan provinces are included in 2015 results since activities reflect COP14 approved activities –before the COP15 pivot.



1.5 Stakeholder Engagement

PEPFAR Angola’s tightened program focus, which began in COP14 and was further refined in COP15, has resulted in deeper integration with GRA in the joint management and oversight of the program. In COP16, PEPFAR Angola will continue to meet with INLS and Luanda Provincial Health Directorate (DPSL) on a monthly basis to review progress and challenges with the PEPFAR Angola management team. This routine dialogue further strengthens communication between GRA entities and has informed the development of COP16. The appointment of a new Minister of Health also augurs well for further ownership and engagement of PEPFAR Angola efforts by the GRA.

Language remains a significant barrier to effective engagement, especially for the written COP product and participation in PEPFAR Management Meetings as most GRA counterparts lack fluency in English. For COP16 however, PEPFAR Angola took steps forward to overcome this barrier by translating the SDS and bringing an interpreter to the COP16 Review Meeting.

COP16 also reflects increased collaboration with UNAIDS. Together, PEPFAR Angola and UNAIDS convened the GRA (INLS and DPSL) in February 2016 and completed stage one of the SID. INLS intends to host stage two of the SID exercise, which would include a wider group of stakeholders including: civil society, private sector, additional MoH offices, and other key GRA ministries. UNAIDS is also committed to strategic engagement and invited the PEPFAR Angola team to its annual strategy presentation in March. The Global Fund is set to return to Angola in July pending approval of the concept note. PEPFAR Angola will share the SDS with both multilateral partners ahead of COP16 review meetings in Johannesburg.

PEPFAR Angola will continue to deepen its engagement with civil society, particularly in regards to key populations. Under the Linkages program, PEPFAR Angola currently supports five CSOs and will support a total of ten by the end of COP16.

PEPFAR Angola will reexamine its private sector engagement strategy in COP16. Angola's current economic crisis has eliminated many sources of funding for corporate social responsibility programs, and has negatively impacted PEPFAR Angola's traditional point of engagement, the *Comite Empresarial Contra HIV (CEC)*. In COP16, PEPFAR Angola will explore areas of engagement with new private sector partners such as prominent local businesses (cell phone companies) and pharmaceuticals.

2.0 Core, Near-Core and Non-Core Activities

PEPFAR Angola's core activities will focus on: TA for care and treatment of PLHIV particularly KPs, strategic information (SI), laboratory strengthening, military priority population, and commodities security. For COP16, PEPFAR Angola has moved supply chain strengthening from a near-core activity to a core activity based on current GRA difficulties with essential HIV commodities –including TA to support the GRA to deliver needed ARVs and testing supplies. Due to the current Angola economic crisis, temporal hiatus of Global Fund support, and incomplete decentralization, GRA capacity to secure needed HIV supplies has been negatively impacted. PEPFAR Angola will increase TA at national (quantification, management and distribution) and facility levels (pharmacy management).

To address SI challenges, PEPFAR Angola will work with national counterparts to improve data quality, documentation, and use at clinical sites through the introduction of an electronic data collection system (SIS), in addition to data entry training and mentoring using M&E specialists. A dual system of data collection (manual and electronic) will remain for quality assurance purposes. SIS has been the foundation for the INLS database since 2004. In COP 16, data from SIS will be migrated to District Health Information System 2 (DHIS-2). The nine PEPFAR Angola supported sites will also use a DHIS-2 platform for the development of a longitudinal data information system for patient tracking that will harmonize with new INLS DHIS-2 system being developed with PEPFAR Angola assistance.

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, and increasing the availability of HIV-related supplies and pharmaceuticals. 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, VL education, and active case finding of those lost to follow up. Quality laboratory and diagnostic support are critical to the continuum of care. Without CD4 it is not possible to determine ART eligibility to initiate ART and without VL testing, it will not be possible to monitor adherence and viral suppression.

PEPFAR Angola will build the capacity of civil society organizations (CSOs) and HCWs to ensure KPs are effectively reached, supported, and monitored appropriately. PEPFAR Angola will continue to support the implementation of KP drop-in centers and community testing to ensure KP access to HTC services. Enhanced linkage to testing, care, and treatment for KPs will be implemented in ten high yield communities in an effort to increase ART coverage. CSOs will also provide VL education at the community level. PEPFAR Angola will train and support select clinics and CSOs to address stigma and discrimination at the clinic and community level. While the GRA has only recently recognized the importance of KP programming, it is planning to implement Test and Start with KPs.

PEPFAR Angola utilizes a data driven programming approach to military programming based on the results of the SABERS study in COP16. PEPFAR Angola's relationship with the military is strong and continues to focus on strengthening military health systems dedicated to HIV prevention, care, and treatment.

Due to low reported condom use and high alcohol abuse within the military population, PEPFAR Angola will assist the Angolan Armed Forces (FAA) in training HIV educators. These educators will provide a comprehensive package of HIV prevention and education to priority military populations through HTC promotion at community and military events and exercises. In order to reach saturation of PLHIV military personnel initiated into treatment, COP16 will focus on current active duty military and continue to support services at fixed and mobile voluntary counseling and testing (VCT) sites in high prevalence geographic locations. COP16 will focus on Test and Start and link all military personnel testing HIV positive to ART at military sites and mobile testing facilities.

3.0 Geographic and Population Prioritization

PEPFAR Angola completed geographic and population prioritization during COP15. In 2014, Luanda represented 30% percent of total PLHIV and 39% of those identified as HIV+. To address this high burden, PEPFAR Angola decided to focus HIV activities in Luanda, working with the GRA to design and implement models of HIV C&T for future transference and scale-up. The MOH's 2015 figures further support the decision to focus attention on Luanda since the figures show that 42% of all new Angolan HIV cases were detected in the province. Luanda's HIV yield of 10.6% in adults and 16% in children is higher than national yields for adults and children (5.4% and 4.9% respectively).

In COP15, PEPFAR Angola started implementing enhanced TA among nine identified healthcare facilities. Sites were chosen based on specific criteria such as: the number of adults and children tested, positive cases, breadth of services included in the continuum of care, and proximity to known KP hotspots.

PEPFAR Angola results from fiscal year (FY) 15 have validated the selection of the nine facilities in Luanda based on first quarter FY16 results for testing yield, cascade, and linkage to care for adults,

children, and KPs. PEPFAR Angola is confident that continuing this strategy will both produce quantifiable results and make the best use of resources, thereby assisting the GRA in containing the HIV/AIDS epidemic and supporting their overall contribution to the ambitious UNAIDS 90-90-90 treatment targets.¹

In COP16, KP activities will expand to two new districts within Luanda province so that PEPFAR Angola will reach targets and advance epidemic control. Based on the results of a baseline assessment from FY16, PEPFAR Angola will adjust KP activities to ensure HIV+ KPs are successfully enrolled in C&T at selected sites in these two districts. Additional program pivots to other provinces remain an option and PEPFAR Angola will revisit its planned strategy when the DHS+ and IBBS results have been disseminated and discussed with the GRA.

PEPFAR Angola will continue to focus on the military in eight selected sites. The military geographic areas targeted for COP16 were selected based on the prevalence data and risk profile developed from SABERS. Focus efforts will target military regions with high prevalence: South (5.4%), East (3.6%), Central (3.5%), and Luanda (2.4%) province. These regions are represented by eight provinces: Bie, Cunene, Huambo, Kuando Kubango, Luanda, Lunda Norte, Lunda Sul and Moxico.

The military program is PEPFAR Angola's only implementation outside of Luanda. The military focus is a critical component to achieving epidemic control, as the military is a highly mobile population with a combined prevalence rate, outside of Luanda, of 12.5%.

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

PEPFAR Angola will program at three levels: above-site, facility and community. PEPFAR Angola will work in 14 above-site locations including national warehouses and laboratories as well as municipal and district governments in Luanda. Through a comprehensive package of TA services, PEPFAR Angola will concentrate on delivering services in nine model health facilities across five municipalities in Luanda. Model sites are health facilities that provide quality HIV/AIDS services based on highly functional systems and capable human resources. Examples of systems that will be addressed in the facilities are: health information systems (HIS), SI, commodity security, provision of quality HIV C&T services including TB/HIV C&T, Test and Start, and laboratory management.

4.1 Targets for scale-up locations and populations

Target selection was largely based on baseline data assessment at the nine model sites. Phase I of the assessment included a review of information from over 2,600 patient files, one-year of daily

¹ By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

ARV dispensing data, one-year of HIV testing data, and information from more than 30 site-staff interviews. Services were mapped; data and patient flow was documented for each site. In phase II, the team conducted the SIMS assessment at all nine facilities. PEPFAR Angola and INLS program data for both clinical sites, as well as KP community work, were considered.

PEPFAR Angola generated targets for COP16 through:

1. The approximate number of PLHIV in Luanda Province was estimated using Spectrum (UNAIDS modeling) Data 14 which showed a national population HIV prevalence of 300,000. Census data estimates that 30% of the population lives in Luanda Province. This results in an estimated 90,000 PLHIV in Luanda Province. This number was entered into the PEPFAR Angola DataPack and subsequently adjusted to reflect current estimated numbers of people with HIV in 2015 to 91,560 (9,119 <15 years of age and 82,441 ≥15 years of age).
2. The number of PLHIV on treatment was estimated using INLS program data. PEPFAR Angola estimates that 34,203 PLHIV are on treatment, leaving 57,357 in need of treatment. PEPFAR Angola needs to reach 39,045 of those currently not receiving treatment in order to achieve “saturation” in Luanda province.
3. Baseline data was utilized to determine an approximate number of people tested for HIV, linked to care, and new on ART. ART coverage rate, retention rate, and treatment current rate was computed for the nine intervention sites in 2015. PEPFAR Datapack (planning and analysis tool) inputs were adjusted to obtain realistic and accurate target outputs. Treatment (TX) targets are based on National AIDS Program 2018 targets. Targets are not as aggressive as possible due to the commodity security uncertainties.

Additional targets for prioritized populations were generated for COP16 through:

1. An examination of PEPFAR Angola implementing mechanism programmatic data for community level KPs.
2. Considering SABERS results and military priorities for the military targets. Military HTC targets were based on the military’s ability to reach 15% of their highly mobile and geographically diverse population.

Critical assumptions were made in determining required resources and setting targets. PEPFAR Angola assumes the GRA will prioritize interventions aimed at epidemic control and continue to procure a level of ARVs needed to comply with national C&T guidelines. Another critical assumption is that funding will continue to be provided to cover clinical staff salaries, equipment, and other C&T guidelines.

Challenges to successfully meet targets exist throughout the implementing environment for PEPFAR Angola. At the national level, the current fiscal climate challenges the supply security of commodities, ARVs, and human resources.

Selected Targets

For testing indicators (HTS), PEPFAR selected three different sets of indicators: facility level (VCT and PITC), community level (testing among key populations), and military settings. Facility-level targets reflect expected testing increase after pivot to focus PEPFAR Angola activities in high-yield clinical facilities. Community-level targets are based on planned increase of community settings to reach most-at-risk key populations. TB_STAT, and TB_ART targets reflect QI COP2015 TB program data at the nine sites. Targets for laboratory Continuous Quality Improvement (CQI) and Proficiency Testing (PT) and (LAB_PTCQI) are based on the SIMS data and 2015 national program data.

SNU	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) <i>TX_CURR</i>	Newly initiated (APR FY 17) <i>TX_NEW</i>	ART Coverage (APR 17)
LUANDA	91560	22080	35708	25417	7753	41%
Total	91560	22080	35708	25417	7753	41%

SNU	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) <i>TX_CURR</i>	Newly initiated (APR FY 17) <i>TX_NEW</i>	ART Coverage (APR 17)
LUANDA	-	1770	-	2051	644	-
Total	-	1770	-	2051	644	-

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
<i>PP_PREV</i>			21,576
<i>KP_PREV</i>			16,500
Total			

4.2 Priority population prevention

PEPFAR Angola will continue to focus on two priority populations: military populations and KPs (sex workers and MSM/TG). This decision was based on the best available knowledge regarding KPs and current data on military personnel from SABERS results.

Military Populations

Geographic focus on targeted military population is based on the prevalence data and risk profile developed from SABERS results. COP16 will align activities towards reaching saturation of the active duty PLHIV military personnel through enhanced testing at fixed and mobile VCT sites. PEPFAR Angola will provide TA to ensure all military personnel identified as HIV+ will initiate antiretroviral therapy and be retained on treatment. Educational interventions (alcohol use and other risk factors) and a comprehensive HIV prevention package, including condom use promotion, will also be supported.

The fundamental core curriculum for military treatment facilities will continue being implemented to support saturation of military PLHIV on treatment. Quality improvement for HIV treatment service providers, through train the trainer modules, will shape field and site level activities. Military PLHIV numbers will be identified through targeted testing activities and expected increase in number of positives currently in the FAA will inform commodity needs in terms of advocacy for test and start, military purchase orders for both laboratory and treatment services as well as orientate the PEPFAR program prioritize support training for C&T systems strengthening.

A main priority will be coordinating and training health care providers, including physicians, on HIV diagnosis, treatment, and clinical management of cases. In COP16, PEPFAR Angola will also support the military in delivery of treatment services for current HIV patients and those newly enrolled on treatment.

In COP15, PEPFAR Angola focused on a technical assessment of the current military laboratory capacity. For COP16, PEPFAR will focus on developing and strengthening laboratory networks and facilities to support HIV/AIDS related monitoring and treatment services. This support will scale up VL capabilities and reporting for up to four designated military facilities in highest HIV burden areas. A recognized and approved quality assurance (QA) system for HIV testing and monitoring laboratories will be implemented gradually and will include training military laboratory technicians at the site level. The FAA's Central Health Division will coordinate this system and ensure appropriate implementation and data collection. This approach aims to increase VL screening and gradually introduce TB testing capacity at remote hard to access military bases.

Key Populations

Although KPs have traditionally not been a focus for the GRA, PEPFAR Angola now works in close collaboration with the GRA on KP programming. The GRA has requested support from PEPFAR Angola for the creation of a KP national plan, as well as KP C&T guidelines and monitoring activities. The GRA plans to expand its KP efforts, based on the PEPFAR Angola model, to another province through Global Fund support. While specific KP policy guidelines are currently

under development by the GRA, the GRA is leading peer counselor trainings as well as other KP activities at INLS and plans to implement Test and Start for KPs. A national KP working group was established to steer programming.

At the community level, prevention interventions, in ten communities in Luanda, will create demand for HIV services. Robust linkages will be established between community-based prevention activities and clinical services. PEPFAR Angola will build upon previous capacity development initiatives to strengthen local CSOs and the GRA to lead efforts ensuring a sustainable response to the epidemic.

Data remains critical to effective prevention by characterizing the epidemic by population and location in order to scale-up coverage of evidence-based prevention interventions. Community SIMS data has not been completed; however, there are plans to finalize Community SIMS 2.0 in Q3 of COP16. To acquire KP data, PEPFAR Angola will support capacity building of ten local CSOs to identify KPs, map hot spots, and estimate population size for improved programming.

Peer outreach is a critical component to PEPFAR Angola KP programming. With peer educators, CBOs will provide a package of prevention services to KPs which will facilitate awareness and promote uptake of stigma-free HIV services. PEPFAR Angola will enhance peer mobilization through the recruitment of peers with greater access to HIV+ networks. Peer educators and HTC counselors working in teams will be responsible for identifying KPs at high risk hot spots and providing KPs with a package of prevention services. Behavior change communication activities will be utilized and include: condoms and water-based lubricant distribution; HTC; syndromic STI screening; GBV support; alcohol and drug abuse support; and risk assessment and risk-reduction counseling; promotion of partner testing; as well as linking KPs from community to PEPFAR Angola supported facilities for clinical services.

4.3 Voluntary medical male circumcision (VMMC)

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

4.4 Preventing mother-to-child transmission (PMTCT)

Based on PEPFAR Headquarters guidance for TA countries, PEPFAR Angola no longer directly supports PMTCT activities in COP16. PEPFAR Angola will continue to support adherence and retention services directed to postpartum HIV+ women.

4.5 HIV testing and counseling (HTS)

In COP15, PEPFAR Angola initiated the provision of enhanced technical support in nine high-yield clinical sites. During the first quarter, 16,598 people were tested for HIV and received their results – with 1,672 positives, resulting in a 10% HIV testing yield.

For COP16, PEPFAR Angola will pilot the implementation of “index patient partner and family testing,” as an important strategy for attaining higher testing yields. This initiative will start with

the improvement of current testing services for partners and family (e.g., all siblings of children with HIV and partners of positive pregnant women) at the facility level with support of trained counselors and peers. PEPFAR Angola will use peers to increase recruitment of partners and family members of HIV+ pregnant women and PLHIV already in care and treatment services. Considering the HIV epidemic in Angola, PEPFAR Angola will implement a pilot to identify the most effective outreach approach (e.g., home-based index case testing) without creating additional sources of stigma and discrimination at the community level.

Although there have not been recent policy or guideline changes, PEPFAR Angola will continue to support GRA to update testing registries and reporting materials to better respond to GRA and international standards. For COP16, HTS will continue as a PEPFAR Angola core activity.

2015 SIMS and additional supervision visits have identified the following problems throughout the nine selected clinical settings: limited staff and lack of personnel commitment to implement VCT and other service delivery points; limited coordination between hospital departments (e.g., tuberculosis) and HIV services to implement PITC; limited technical capacities to implement PITC due staff turnover, lack of visible SOPs and job-aids, and lack of proficiency monitoring; limited availability of testing materials; incomplete testing registries; limited testing among partners and family members of PLHIV; limited link to C&T services; lack of a routine QI system and inability to count individuals tested for HIV versus HIV tests. Baseline data identified poor linkage from HIV+ test result to treatment; of the 7,394 positive test results only an estimated 3727 were linked to treatment. 2014 National adult testing data for Luanda province showed that 38% of those testing positive were linked to treatment. PEPFAR Angola used these results to adjust its TA during COP15 and better plan activities for COP16 on aggressive scale-up SNU. All selected facilities, communities, and military sites will aggressively scale-up testing activities as a mandatory initial step for epidemic control and future implementation of Test and Start.

As a TA program, PEPFAR Angola cannot hire personnel for service provision or procure additional testing materials. In COP16, PEPFAR Angola will provide TA to update testing guidelines, registries, SOPs, and job-aids to be used at all hospital services. More importantly, PEPFAR Angola's main priorities for COP16 include the design, implementation, and documentation of testing workflow adjustments to facilitate internal coordination and effective link to C&T services. Workflow adjustments should motivate facility staff to included HIV testing in their everyday work.

PEPFAR Angola will reinforce the implementation of routine and systematic PITC in adult, pediatric, and TB services with prioritization for in-patient, malnourished children, and TB+ cases. PEPFAR Angola will support PITC by providing TA, mentoring, and training to clinical staff at the nine selected facilities.

Stock-outs of testing supplies are a major problem in Angola. To increase security of testing supplies at all service delivery points, PEPFAR Angola will assist in the design and implementation of simple tools and methodologies to improve pharmacy management, coordinating with INLS and national warehouses to ensure commodity availability and internal

distribution. In addition, PEPFAR Angola will assist local labs to implement proficiency monitoring of HIV tests.

PEPFAR Angola will provide technical assistance to the INLS and target facilities to develop a longitudinal information system in COP16 and address data gaps. Activities include: training facility staff on standard practices for use and completion of registers, completing the notification form for all individuals identified as HIV positive, conducting data quality assessments, and mentoring and monitoring staff to ensure proper data documentation and reporting.

PEPFAR Angola will also focus significantly on HTS activities for KPs through peer and counselor-based outreach. Based on COP15 results, PEPFAR will improve the identification and selection of KP hot spots to target sub-populations at highest risk and increase testing yields. PEPFAR Angola will assist selected clinics with effectively linking KPs with appropriate HIV care services. In addition, PEPFAR Angola will build capacity of local CSOs to support community testing services (hot spots, drop-in center, index case, home based, and via mobile clinics). TA will be provided to CSOs to increase yield by targeting high risk sex workers and MSM/TG, screening KPs for risk behaviors prior to testing, focusing on high risk hot spots, and identifying KPLHIV and linking them to C&T services.

Military personnel, especially permanent personnel, will receive prevention education and testing. PEPFAR Angola will improve quality control for HIV testing at fixed and mobile VTC sites through:

- Training HIV educators on HTC promotion at military wide events and exercises
- Training military health service providers in QI and QA testing
- TA to support the FAA trainers to coordinate and train health care providers (physicians on HIV diagnosis, treatment, and clinical management)
- Linkages to treatment of all military personnel testing positive for HIV at military sites and mobile testing facilities
- Upgraded military laboratories to respond to the increase in HIV patients' treatment
- Development and strengthening of laboratory networks and facilities monitoring

4.6 Facility and community-based care and support

The role of community support systems and structures cannot be underestimated in the effort to achieve epidemic control of HIV. Testing and retention interventions will be initiated in the facility and linked to the communities. For example, community contact tracing of family members of individuals testing HIV+ at the facilities will be undertaken. In an effort to increase retention, support groups will continue to be offered at the facility where HIV+ patients are cared for, and community patient adherence groups will be implemented in areas where patients live. In order to increase linkage to care, KPs testing positive at community drop-in sites will be accompanied to PEPFAR Angola supported sites for treatment. In COP16, PEPFAR Angola will continue mentoring and training healthcare workers to reinforce retention efforts and treatment adherence. Retention efforts will include adherence clubs at the facility, psychological and

nutritional support, as well as community-level individual support using a peer-based approach. Retention activities will be included in QI plans at each selected facility.

At the facility level, HCWs will be trained on stigma and discrimination-free services as well as C&T needs of KPs. Peer navigators/counselors will reduce barriers to access HIV services by linking KPs from community to facility, following KPLHIV along the continuum to guarantee that KP needs are met stigma-free. In addition, to improve retention and treatment adherence, increase community VL education, and reduce loss to follow-up (LTFU) amongst KP, a modified PAF model will be adapted to link HIV+ KPs to support groups.

Community programming is central to supporting effective services along the prevention, care, and treatment continuum. PEPFAR will support community approaches that facilitate early diagnosis and rapid ART initiation (mentor mothers, and ART buddies), as well as community approaches that support adherence and retention in care such as the establishment of KPLHIV community adherence and support groups and KP Peer Positive Living Promoters. Positive Living Promoters provide home-based psychological support and vocational training courses.

4.7 TB/HIV

Angola is among the 22 highest TB burden countries in the world. In Luanda, there were 21,986 registered cases of TB in 2014. Of these cases, 18% were HIV+. In COP16, PEPFAR Angola will prioritize scale-up of services and linkage to HIV C&T for TB/HIV co-infected patients. One clinical implementing partner will lead the scale-up of TB/HIV activities and provide TA at the nine facilities within this program area.

A SIMS facility based assessment was conducted at all nine sites during the first quarter of COP15. This data was used to inform program approaches and activities. Among the major deficiencies noted in the area of TB/HIV include:

- Inadequate documentation tools to assess compliance of national standards (ART initiation date/ regimen, routine TB screening, current ART regimen for TB/HIV patients);
- Deficient integration between services (e.g., HIV and TB) and facilities (e.g., pediatric patient referrals);
- Lack of routine TB screening;
- Inadequate ART monitoring and management of co-infected patients were missing in the majority of patient clinical files;
- Inadequate infection control practices

Angola has adopted the WHO 2013 guidelines recommending the initiation of ART in all patients with active tuberculosis infection regardless of CD4 cell count; however, guidelines are still not fully implemented. In COP16, TA will be provided at the intervention facilities to ensure: 1) all TB patients are tested for HIV and if positive initiated on ART within two months of beginning TB treatment 2) HIV+ patients will be screened for TB at every visit and screening will be documented and; 3) WHO 2013 guidelines will be fully implemented.

PEPFAR Angola TA will also focus on improving communication and coordination between TB and HIV units, to facilitate better monitoring and ensure proper linkage to services. Program baseline data suggests approximately 20% of HIV+ TB patients were linked to C&T within two months of initiating TB treatment. In COP16, PEPFAR Angola intends to pilot, in at least one intervention site, a one-stop-shop model for TB/HIV services. PEPFAR Angola aims to increase early linkage rate (2-8 weeks) among newly diagnosed co-infected TB patients to 70% at the nine model sites. HIV positive clients with presumptive TB will be tested for TB using smear microscopy and GeneXpert services that will be available at three intervention sites and the TB reference lab. A referral system will be developed for patients being seen at the sites without the GeneXpert. Clients with diagnosed HIV/TB co-infection will be monitored and linked to treatment services according with existing protocols pertaining to the following:

All TB and HIV patients will be offered a basic TB/HIV package of care:

- TB patients will be tested for HIV. Contact tracing, cotrimoxazol TB infection control (TBIC), nutrition assessment and support and adherence counseling will be provided to all co-infected patients
- HIV patients will be routinely screened for TB at every visit, and isoniazid prophylactic therapy (IPT), and ART will be provided for all co-infected patients. TB infection control, nutrition assessment and adherence counseling will also be offered.

PEPFAR Angola IPs will work with INLS to support revision of current CTX guidelines (CD4< 200) to include universal CTX for all PLHIV and TB/HIV co-infected patients. PEPFAR Angola will work closely with INLS to revive the TB/HIV technical working group, review its terms of reference, and review the TB/HIV collaboration guideline. PEPFAR Angola has also included in its plan joint training and the harmonization of monitoring and evaluation/information systems to improve delivery and management of services.

TB infection control is an important systems-level activity to reduce nosocomial infections for PLHIV and TB infection among health care workers. The SIMS facility assessment showed five of eight TB/HIV units had below minimum standard infection control practices. In 2014-2015, the TB reference lab was closed for one year for renovations due to lack of biosafety certification and ventilation. PEPFAR Angola will provide TA at the national, sub-national and site level to implement an infection, prevention, and control (IPC) policy, guidelines, and M&E tools. Site-level interventions for TBIC will focus on improved ventilation, hygiene, isolation of suspected and confirmed cases, and decongestion to reduce TB transmission at health care facilities.

4.8 – 4.9 Clinical care of adults and pediatrics

In 2015, the GRA refocused its programming to better align with PEPFAR Angola objectives of improving the continuum of C&T for people living with HIV as well as improving data quality. PEPFAR Angola prioritized scale-up of adult and pediatric C&T service activities in Luanda at nine health facilities. These facilities will receive a comprehensive package of TA services to deliver high quality HIV/AIDS C&T in Luanda.

Support will be provided to INLS to create and strengthen technical working groups (TWGs) for HIV C&T, pediatric C&T, TB/HIV, and M&E to ensure that all key program areas have a forum for discussion. PEPFAR Angola will meet with INLS monthly to provide feedback on challenges identified in the field and coordinate an adequate response. The IPs will support INLS to implement and scale-up VL through the development of tools, SOPs, algorithms, and other support materials, as well as the implementation plan.

PEPFAR Angola has identified two IPs to scale-up adult and pediatric C&T activities, each one working differently. One implementing partner will provide daily technical assistance and oversee day to day activities at the nine sites. The other will provide technical assistance to INLS to define policy, standards, and packages.

The IP on the ground each day will ensure that patients identified as HIV+ are immediately linked to care. The IP will also oversee patient tracking and adherence, including the implementation of facility-community support systems and structures. The baseline found a LTFU rate of approximately 30% in the first three months of ART and 54% for individuals in their first year of ART. Of all pre-ART patients, 72% were LTFU in their first year. To address this, PEPFAR will provide TA at several levels to increase retention and adherence through better facility-community linkages, incorporate appointment/patient tracking systems, and strengthen adherence counseling in the model sites.

The other IP will be responsible for providing oversight and weekly technical assistance visits for adult and pediatric C&T. The IP will provide ongoing TA to INLS to define standards and packages of HIV C&T, establish/revise strategies, guidelines and implementation plans for HIV C&T. The implementing partner will work with other IPs to ensure the recommended processes for development and clinical interpretation of VL are implemented. The IP will work with INLS and the data management partner to assist with DHIS implementation and ensure that C&T program data are reviewed and utilized by clinicians to improve the quality of HIV C&T services.

The two clinical partners will be supported by a laboratory partner, a logistic/pharmacy partner, and a data management partner. The laboratory partner will build capacity of the national laboratory to implement a phased approach to routine viral load monitoring and assist to develop a sample transport mechanism for the dried –blood spot (DBS) VL samples. They will provide technical assistance to ensure quality CD4 tests are offered daily so that patients with CD4 count of <500 can initiate ART immediately and VL monitoring to assess adherence and viral suppression among those on ART. The laboratory partner will also support continuous quality improvement efforts through mentoring and supportive site supervision to ensure biosafety and high quality diagnostic services in the HIV and TB reference laboratories and in the nine PEPFAR Angola supported sites. The pharmacy partner will assist health facilities to assess inventory and ensure adequate supplies of ARTs. The data management partner will make sure all HIV positives are notified and will assist with developing systems for patient scheduling and longitudinal tracking of individual patient clinical data (HIV testing results and ART pick-up).

At the end of FY 2015, a baseline data collection effort was completed at the nine PEPFAR Angola supported health facilities in Luanda. To assess adult and pediatric C&T, 2,631 clinical processes

of HIV patients were reviewed, and SIMS facility based assessment was conducted. This data was used to inform program approaches and activities. Strengths identified by SIMS in the area of adult and pediatric C&T included initiation of efforts for facility-level patient tracking procedures, adherence support, ART monitoring in both adults and children, and CD₄ monitoring and documentation. Adult and pediatric C&T service delivery challenges identified in the SIMS facility assessments were numerous and included lack of SOPs, medical records, unclear HR guidance for staff, poor M&E, limited QI, and absence of VL.

The SIMS assessment findings provided constructive feedback to the nine sites and set the stage for launching work plan development efforts. Using the results as a foundation for program planning, PEPFAR Angola and all IPs collaborated to develop site-specific work plans in all program areas and to rapidly launch remediation activities.

In 2015, GRA revised the HIV clinical C&T guidelines in accordance with 2013 WHO guidelines for ART initiation at < 500 CD₄ cell count. However, these guidelines were not widely shared or disseminated to clinicians. All children less than five years of age and all pregnant HIV+ women are eligible for ART irrespective of CD₄ count under the current C&T guidelines. However the baseline data survey showed that only 61.8% of those <5 years at the nine PEPFAR supported sites initiated ART and national program data for Luanda, PMTCT in 2015 shows that 66% (2692/4057) of pregnant women identified as HIV positive initiated ART.

In COP16, PEPFAR Angola will assist the national partner in developing systems needed to increase the number of people on treatment and implement Test and Start. PEPFAR Angola will support INLS to review and revise the current national package of care and to adopt the WHO differentiated models of care for Test and Start. Evidence-based interventions will be piloted to reduce overburdened facilities by promoting less frequent visits for clinical consultation and drug pick-up for stable patients. This will permit clinicians to see more patients and to spend more time with non-adherent and/or patients with detectable VL, and to fast-track and schedule more frequent visits for sicker patients. PEPFAR Angola will make sure that ART is initiated after the first positive PCR (polymerase chain reaction) for all infants. PEPFAR Angola will provide in-service training, mentoring and supportive supervision and conduct continuous quality improvement activities in the nine supported health facilities in order to improve patient management and identify bottlenecks and corrective measures to improve C&T services.

All patients will receive a basic/core package of care including viral load and CD₄ monitoring; STI screening and treatment; routine TB screening; TB diagnosis & treatment; IPT for TB prevention; cotrimoxazole prophylaxis; nutritional assessment and adherence counseling; support with disclosure and partner notification; referral to support groups; family planning counselling and screening for opportunistic infections. Screening for opportunistic infections will include screening for cough, fever and STD symptoms at each visit. CD₄ cell counts will be monitored; patients presenting with cell a cell count less than <200 or with a decreasing cell count will be examined and if warranted referred for further work-up. PEPFAR Angola will continue mentoring and training HCWs to reinforce retention efforts and treatment adherence. Program officers and peers will mentor and support facilities' staff to improve treatment retention by

identifying LTFU patients using clinical and ART records and actively track and re-start C&T. In COP16, retention efforts will include adherence clubs at the facility, psychological and nutritional support, and community-level individual support using a peer-based approach

After initial clinical consultation, patients will receive differentiated model of services, based upon specific patient criteria. New patients enrolled in care will receive intensive care by provider (i.e. monthly consultations) and all initial clinical and lab evaluations. For early presenters, subsequent visits will be focused on adherence and drug pick up. For late presenters, subsequent visits will include a clinical assessment. For patients on treatment, the package of care will depend upon whether or not the patient is stable. For instance:

- Stable patients' package of care includes longer intervals between clinical consultations and drug pick-up (6 months/3months respectively – depending upon availability of ARV);
- Un-stable patients and sick patients will be fast-tracked for clinical consultation through implementing a triage system. They will be seen monthly to ensure opportunistic infections are diagnosed and treated early. VL will be monitored for early identification of patients with detectable VL (therapeutic failure) and patients will be change to second line after completing adherence counseling and adherence protocol.

The Systems Budget Optimization Review (SBOR) exercise revealed several areas of concern with regards to sustainability and scale-up of C&T services, including the gap for ARVs and other HIV commodities and the need for trained human resources for health (HRH). PEPFAR Angola has recently (January-March 2016) experienced shortages of HIV test kits, VL and EID kits, and ARVs. VL and EID are not currently being processed in the referral lab due to stock-outs of reagents. All PEPFAR Angola supported health facilities are receiving fewer ARVs and HIV test kits than requested.

With Angola's continuing financial crisis, coupled with ART scale-up, there is a potential for ARV gaps in both calendar year 2016 and 2017, as well as a gap for rapid test kits. There is a significant gap projected for EID and VL commodities in 2016. These gaps are primarily related to insufficient resources to support the scale-up to reach 90-90-90 targets and weaknesses in inventory and supply chain distribution practices. GF is expected to provide a limited supply of ARVs and rapid test kits as well as a VL machine (no VL reagents) beginning in July 2016. However this may not meet the increased demand for commodities from the nine model intervention sites.

4.10 OVC

Not applicable to Angola.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services and expected volume in sustained support 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 through replicable activities in scale-up locations and populations.

Table 5.1.1: Not Applicable

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

This is not applicable to PEPFAR Angola.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

In effort to achieve sustained epidemic control, PEPFAR Angola plans to address three key programmatic gaps to strengthen current health systems and support new priority policies such as Test and Start. These three key programmatic gaps are: 1) Human Resources for Health, 2) Commodity Security and 3) Linkage to care. To best address these gaps, PEPFAR Angola has identified activities and necessary funding sources to address specific impediments. PEPFAR Angola has identified key system barriers for each gap that will need to be addressed within COP16 activities to promote the roll-out of Test and Start and new service delivery models. These selections have been informed by the SID analysis, the SBOR process and include the required metrics to be used to monitor the impact of USG TA.

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

Gap 1, Human Resources for Health:

Human Resources for Health is a key programmatic gap for PEPFAR Angola due to its overarching influence on the success of the existing health system in Luanda. In addition to a lack of staff per facility within the province, there is inadequate Human Resource guidance, a lack of technical expertise and an insufficient staff education system.

Inadequate Human Resource guidance in Luanda refers to a lack of formative supervision, HIV Care and Treatment guidelines. This barrier contributes to an overall inadequacy to meet to demand as well as assure quality improvement of services. To address this, PEPFAR Angola plans to build capacity at all nine facilities by providing TA to update HIV C&T guidelines, management SOPs and job aides.

A lack of technical expertise influences the quality of strategic development and M&E. In Luanda province, there is a lack of technical expertise which has created poor quality HIV information systems and monitoring. PEPFAR Angola plans to address this barrier through the contracting of an SI Advisor and providing technical assistance to create a national guideline for KPs.

A barrier that affects all of HRH is the insufficient staff education in Luanda due to a lack of updated training for HIV care providers to discuss best practices for HIV care and treatment for patients, including stigma-free care for KPs. PEPFAR Angola plans to address this barrier by providing specialized technical lab training as well as conducting workshops for HIV care providers to implement quality care and treatment guidelines.

Gap 2, Commodity Security:

Commodity Security is important for the success of 90-90-90 targets and overall epidemic control. In Luanda, there are insufficiencies with commodities at both the pharmacy and laboratory levels due to poor planning, resource constraints (i.e. foreign currency shortages), poor forecasting and inadequate infrastructure. Specifically, there is an insufficient amount of HIV commodities and lab equipment.

Insufficient HIV commodities and lab equipment impede HIV treatment and retention. PEPFAR Angola plans to create a system of well-stocked pharmacies in select healthcare facilities in COP16 through strengthening supply chain management, tracking ART retention and implementing HIV Drug Resistance Early Warning Signs (EWIS).

A lack of lab supplies and equipment decreases lab capacity to address CD4 and VL. PEPFAR Angola plans to address this barrier through the purchase of Genexpert machines and supplies in order to equip laboratory with the means necessary to meet the demands of Test and Start.

Gap 3, Linkage to Care:

In Luanda in FY16, only 48% of HIV+ cases were linked to treatment. Such low linkage to care can be attributed to many factors but two of the most pressing barriers in Luanda for FY17 are a lack of reliable information systems and an inadequate retention in care. These barriers create poor linkage to care, data duplication and poor HIV+ patient retention.

PEPFAR Angola plans to address the lack of reliable information systems in Luanda by improving the national electronic HIV data management system. This will be done by focusing on data quality, collection, use and management. PEPFAR Angola will support the production of a functional HIV tracking and reporting.

Inadequate retention in care prevents epidemic control in Luanda as HIV+ patients are not retained in care and treatment. In order to address this barrier, PEPFAR Angola will update testing, C&T and retention SOPs, implement quality improvement tools to achieve 90% linkage to care, and initiate a community pilot program to strengthen retention.

Table 6.1.1 Key Programmatic Gap #: Humans Resources for Health						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Inadequate HR Guidance [HRH, Governance]	1. All 9 model clinics demonstrate capacity to fully meet demand for test & treat	TA for Formative supervision activities (above sites INLS, DPS,RMS)	OHSS, HTXS, PDTX, HVCT, HBHC	\$148,736	SASH, TBD 2 (formally SASH)	7. Health for Human Resources (5.25)
	2. Staff-wide distribution of HIV service delivery guidelines, SOPs and job aides at all 9 model clinics	TA to INLS to update SOPs, guidelines and job aides on HIV adult and pediatric C&T and management of treatment failure (including virologic failure)	HTXS, PDTX	\$100,000	ICAP	6. Service Delivery (3.24)
		Update, implement, and monitor testing, C&T, and retention SOPs, norms, protocols, guide lines, manuals, tools	OHSS, HTXS, HVCT, PDTX	\$264,169	SASH, TBD 2 (formally SASH)	
Lack of Technical Expertise [HRH, Governance]	1. Additional staff to support M&E and SI	Second M&E advisor for supportive supervision to INLS for development of national HIV M&E strategy (including VL M&E framework), and monitor HIV information system to strengthen HIV C&T M&E, TA to INLS to conduct HIVDR ADR/PDR evaluation	HVSI	\$250,000	ICAP	7. Health for Human Resources (5.25)
	2. Development of a National Workplan for HIV SI and M&E					
	3. Improved TA for HIV C&T and KP M&E	Contract SI/epidemiologist to assist to develop National SI workplan including HIV M&E, revision of patient (clinical and lab) forms, registers, assist w/analysis of program data and special studies to inform program decision making	HVSI	\$150,000	MOH/INLS	15. Performance Data (6.94)
	4. National policies and guidelines to provide HIV services among KP completed and distributed					
		TA to National HIV/AIDS Institute on Creating National Guidelines for KPs, Workplan, and improved information system	OHSS, HVCT, HBHC,	\$42,811	LINKAGES	
Insufficient Staff Education System [HRH]	1. Workshops, educational seminars and trainings for HIV/AIDS care providers	Staff in 4 military reference labs, trained to performed specialized lab techniques including CD4 and viral load tests, support strengthen referral networks within a system of tiered laboratories ,enable development of planning protocols, sorting and clarifying of logistics as well as implementation of evaluating pilots of the lab network referral system.	HLAB	\$250,000	Military	10. Laboratory (2.92)
	2. Specialty Training for technical areas such as laboratory					
		Organize and/or prepare workshops, courses and seminars for health care professionals and master students on C&T of HIV/AIDS, STIs and related opportunistic infections	OHSS	\$100,000	MOH/School of Public Health	
TOTAL				\$1,305,716		

Table 6.1.2 Key Programmatic Gap #2: Commodity Security						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Insufficient ARVs, other HIV supplies, and equipment [Systems Development, Finance]	<ol style="list-style-type: none"> Improved distribution and supply of essential HIV commodities Pharmacy management systems in place at all 9 clinics Supply chain model in place 	TA to INLS, National and provincial warehouses, and other supply chain organizations to improve HIV commodity (ARV, RTK, condoms, etc.) security and supply chain	OHSS	\$380,157	TBD 1 (formally SIAPS)	8. Commodity Security and Supply Chain (2.93)
		TA at the facility pharmacies to improve commodity security, implement HIV Drug Resistance Early Warning Indicators (EWIs), and track ART retention and transferences	OHSS	\$887,032	TBD 1 (formally SIAPS)	8. Commodity Security and Supply Chain (2.93)
Lack of lab equipment and supplies [Systems Development]	<ol style="list-style-type: none"> Capacity to support Test & Start at all PEPFAR supported facilities 	Purchase Genexpert machines and supplies	HVTB	\$200,000	APHL	10. Laboratory (2.92)
TOTAL				\$1,467,189		

Table 6.1.3 Key Programmatic Gap #3: Linkage to Care						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP ¹⁶	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lack of Reliable Information Systems [Strategic Information, Systems Development]	1. Functional IT system for tracking individuals tested and allows for 100% HIV+ reporting	Improve National electronic HIV data management system focusing on data quality, collection, use, management, analysis and dissemination of HIV data	HVSI	\$300,000	MOH/INLS	15. Performance Data (6.94)
	2. Deduplication of data between USG Partners	In collaboration with other USG partners, SPH graduate students will assist with HIV related SI activities, and reporting at PEPFAR supported clinics	HVSI, OHSS	\$100,000	MOH/School of Public Health	15. Performance Data (6.94)
Inadequate Retention in Care [Systems Development, Strategic Information, HRH]	1. At least 80% treatment retention among 9 selected facilities	Index case pilot and community support pilot to strength testing, retention and care	HVSI, OHSS	\$239,749	SASH, TBD 2 (formally SASH)	6. Service Delivery (3.24)
		Implement quality improvement tools for testing, C&T, and retention	OHSS, HTXS, HVCT, PDTX	\$83,161	SASH, TBD 2 (formally SASH)	9. Quality Management (2.95)
TOTAL				\$722,910		

6.2 Critical Systems Investments for Achieving Priority Policies (Test and Start, Service Delivery Models)

The four most critical systems barriers to address to support successful implementation of new WHO guidelines for Test and Start include: 1) lack of national policy and guidelines for Test and Start, 2) lack of viral load system to manage ART, enhance adherence and monitor viral suppression, 3) inadequate planning and funding for the purchase of ARVs and testing materials, and 4) lack of trained personnel to initiate and track Test and Start.

In FY17, PEPFAR Angola will: 1) support INLS to review and revise the current national policy and guidelines for care and treatment (C&T); 2) assist INLS and DPS to design and implement improved C&T models in 9 selected – including standard operating procedures (SOP), job aides, staff capacity-building activities, improved registries and M&E systems, and quality improvement methodologies-prior to beginning Test and Start. In addition, VL SOPs, sample transport mechanisms and QA systems for VL will also need to be developed.

Table 6.2.1 Test and Start						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP ¹⁶	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lack of a national policy on Test and Start [Governance, Systems Development]	1. National policy and guidelines for Test and Start developed, distributed and under implementation.	TA to INLS to develop national policies and guidelines	OHSS	\$100,000	ICAP	3. Policies and Governance (7.82)
Inadequate HIV Service Delivery System [Governance, Financing, Human Resources, Service Delivery, Systems Development]	1. National and local HIV budgeted operational plan updated with the inclusion of Test and Start approach (including VL)	TA to INLS to develop technical norms and performance standards to improve patient registries, reporting and preparing statistics to support Test and Start	HVSI	\$80,000	ICAP	9. Quality Management (2.95)
	2. Developed technical norms and performance standards to improve SOPs, guidelines, patient registries, reporting and preparing statistics for Test and Start	Develop a National and Sub-national C&T operational plans (including VL lab referral network, development and implementation QA systems clinical guidelines, SOPs, register revision for implementation, M&E framework, HIVDR ADR/PDR evaluation)	HLAB, HBHC, PDTX, HVSI	\$300,000	MOH/INLS	10. Laboratory (2.92)
	3. INLS and healthcare workers with technical capacities to implement test & start	Development of algorithms, job aids, counseling tools, training material, training and mentoring for HCW' on VL and VL interpretation	HTXS, PDTX	\$100,000	ICAP	5. Service Delivery (3.24)
	4. Commodity security to					

	permit 3-month ART pick-up at 9 PEPFAR supported sites	TA to INLS, National and provincial warehouses, and other supply chain organizations to improve HIV commodity (ARV, RTK, condoms, etc.) security and supply chain	HSS	\$38017	TBD 1 (formally SIAPS)	8. Commodity Security and Supply Chain (2.93)
		TA to INLS to develop the implementation plan for "Test and Start" including SOPs, guidelines, training, optimized service delivery package. Develop a VL operational plan (including targets, costing, sample collection), in conjunction with lab IP and VL lab referral network. Development and implementation of QA systems and clinical guidelines, SOPs, register revision for implementation and M&E framework	OHSS	\$100,000	ICAP	6. Service Delivery (3.24)
Inadequate Lab Capacity to manage ART, enhance adherence and monitor viral suppression [Laboratory, Systems Development]	1. 9 labs at the PEPFAR supported sites with capacities to support test & start implementation 2. Lab QI and QA institutionalized in selected facilities and evidenced by passing score (light green or better) on SIMS relevant lab	Provide 9 lab mentors based at the site to strengthen lab capacity to support Test and Start	HLAB	\$150,000	APHL	10. Laboratory (2.92)
		Support quality testing initiatives including EQA of rapid testing, CD4, and TB screening through continuous QI	HLAB, HVTB, HBHC	\$250,000	APHL	9. Quality Management (2.95)
		Support lab auditing and participation in trainings and conferences	HLAB	\$100,000	APHL	9. Quality Management (2.95)
TOTAL				\$1,218,017		

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lack of Quality HIV Care and Treatment Services, including Key Pop Services [HRH, Governance, Systems Development]	<ol style="list-style-type: none"> All 9 model clinics provide stigma free services to KPs All 9 model facilities achieve 90% linkage from test to treat 	TA to 9 health facilities to provide KPs with effective HIV Services along the care and treatment cascade free of stigma and discrimination	OHSS, HVOP, HBHC	\$69,000	LINKAGES	6.Service Delivery (3.24)
		Support health facilities for HIV service quality, compliance with national guidelines (ARV optimization, service delivery optimization, VL monitoring and results utilization, clinical management) and data utilization/performance review for the development/implementation of quality improvement plans	HTXS, PDTX	\$200,000	ICAP	7. Health for Human Resources (5.25)
		TA to INLS and National TB Program to update SOPs, guidelines and job aides on HIV/TB C&T, TB infection, prevention control, and DR TB screening and referral systems	HVTB	\$150,000	ICAP	
		TA to INLS, National and provincial warehouses, and other supply chain organizations to improve HIV commodity (ARV, RTK, condoms, etc.) security and supply chain	OHSS	\$380,157	TBD 1(formally SIAPS)	8. Commodity Security and Supply Chain (2.93)
Lack of Contact Testing and Retention efforts [Institutional and Organizational Development, Systems Development]	<ol style="list-style-type: none"> Routine implementation of patient partner and family HIV testing, all sites will score at least light green on relevant SIMS indicators Fully implemented data management system that permits longitudinal tracking of individual patients from HIV diagnosis to drug pick-up to results of VL monitoring at the 9 PEPFAR supported sites Updated HIV case reporting system with 100% HIV+ Notification 	Index case pilot and community support pilot to strengthen testing, retention and care	HVSI, OHSS	\$239,749	SASH/TBD	6.Service Delivery (3.24)
		Improve National electronic HIV data management system focusing on data quality, collection, use, management, analysis and dissemination of HIV data.	HVSI	\$300,000	MOH/INLS	15. Performance Data (6.94)
		In collaboration with other USG partners, SPH graduate students will assist with HIV related SI activities, partner notification, contact tracing, review of registries and logs, data flow and reporting at PEPFAR supported clinics	HVSI, OHSS	\$100,000	MOH/School of Public Health	15. Performance Data (6.94)
		Update, implement and monitor National HIV case reporting/notification	HVSI	\$100,000	MOH/INLS	6.Service Delivery (3.24)

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Finance							
N/A							Domestic Resource Mobilization (5.83)
Governance							
N/A							
HRH - Systems/Institutional Investments							
HRH	TA for HRH for HIV/AIDS services	Sustained Epidemic Control	1. Strengthened HIV Service Delivery Planning	\$214,500	OHSS	SASH, TBD 2 (formally SASH)	6.Service Delivery (3.24)
Inst & Org Development							
Civil Society	TA to 10 CSOs on organizational development, Monitoring and Evaluation, and Finance	Sustained Epidemic Control	1. Increased CSO capacity to contribute to and support 90-90-90 goals -- measured through baseline and annual capacity and performance assessments	\$213,189	OHSS, HVOP	LINKAGES	Civil Society Engagement (6.43)
Laboratory							

Lab System Capacity	Provide training and supervision on DBS sample collection, and support a sample transportation system for VL	Second 90, Third 90	<ol style="list-style-type: none"> 1. Strengthened Lab Transport for VL samples 2. Technical guidance for sample collection 	\$150,000	HLAB	APHL	Laboratory (2.92)
Laboratory	Laboratory improvements at INLS to use COBAS 96 and optimizing workflow	Sustained Epidemic Control	<ol style="list-style-type: none"> 1. Improved laboratory workflow 	\$70,000	HLAB	APHL	Laboratory (2.92)
Strategic Information							
Strategic Information	DHS+ dissemination of results and using them to inform decision making in policies and programs	Sustained Epidemic Control	<ol style="list-style-type: none"> 1. Informed policy and programming planning based on available comprehensive data 	\$125,000	HVSI	DHS7	13. Epidemiological and Health Data (6.49)
Systems Development							
Service Delivery Strengthening	Strengthen 4 military laboratories to expand viral load, increase CD4 count capacities, introduce TB testing, and enable ability for specimen referral networks within a system of tiered laboratories	First 90, Third 90	<ol style="list-style-type: none"> 1. Strengthen military lab capacity 2. Improved CD4 count systems 3. Improved testing and treatment for HIV/TB co-infections 	\$75,000	HLAB	Charles Drew University	6. Service Delivery (3.24)
TOTAL				\$ 847,689			

7.0 Staffing Plan

As the program goal for COP16 remains substantially the same as the program goal for COP15, PEPFAR Angola is not proposing substantial changes to the staffing footprint.

PEPFAR Angola proposes the creation of a new SI Position that reports to the PEPFAR Coordinator and functions in an inter-agency capacity. Creating this new position outside of CDC recognizes the challenges the agency has faced in finding in-house candidates. Relocating the SI position to the Coordinator's office will allow the PEPFAR team to use the more flexible USAID Personal Service Contract (PSC) hiring mechanism and tap into a wider applicant pool available on the open market.

For the PEPFAR Coordinator position, PEPFAR Angola looks forward to the arrival of a new coordinator in May. This will be the coordinator's first experience in the role. PEPFAR Angola therefore proposes that a mentor be identified to guide the coordinator in their first year on the job. The team would like to propose a TDY by the Angola country lead to train the new coordinator for a three to four-week period. Post has been without a coordinator for over six months and believes in-country training would be most relevant.

For SIMS requirements, the entire PEPFAR team plans to carry out SIMS within existing resource levels.

LONG TERM VACANT POSITIONS:

CDC currently has two long-term vacancies: the Public Health Specialist C&T and an Admin Assistant. The positions were approved in COP15 and remain unfilled. During COP15 and at the direction of the Front Office, CDC prioritized staffing the Deputy Country Director position ahead of these two FSN positions. With the Deputy Country Director position filled, CDC will now move ahead to gain Front Office clearance to staff these remaining positions.

PROPOSED NEW POSITIONS

The SI Advisor position within the office of the PEPFAR Coordinator described above has the support of OGAC, the inter-agency team and Embassy Luanda Front Office. The position will provide much needed expertise to comply with requirements for PEPFAR Oversight Accountability Response Team (POART) and COP processes and other standard OGAC reporting including DATIM, SAPR, and APR. Programmatically, the position offers PEPFAR Angola the capacity to further the use of data for decision-making, especially with the release of census data last month, DHS+ and IBBS data later this year, and on-going improved data coming out of the model facilities.

CHANGES TO COST-OF-DOING BUSINESS

Angola's fiscal crisis as result of the low cost of the price of oil remains the most significant factor that could impact PEPFAR Angola cost of doing business (CODB). The past year has seen significant inflation and devaluation of the kwanza against the US dollar. The team is not aware of additional factors that could impact CODB.

	Status	Position	Agency	Category	Primary Focus
1.	Filled	PEPFAR Coordinator	State	USPSC	PEPFAR Inter-agency team leader; General Support
2.	Vacant	SI Advisor	State	USPSC	Strategic Information (Core)
3.	Filled	HIV Program Manager	DOD	FSN	SI, C/T, Prevention (Core)
4.	Filled	Country Director	CDC	USDH	Strategic Information (Core) Care and Treatment (Core) Laboratory (Core)
5.	Filled	Deputy Country Director	CDC	USDH	General Support
6.	Filled	Senior Lab Advisor	CDC	FSN	Laboratory (Core)
7.	Filled	Cooperative Agreement Manager/Budget Analyst	CDC	FSN	General Support
8.	Filled	Public Health Specialist – Surveillance/M&E	CDC	FSN	General Support Strategic Information (Core)
9.	Unfilled	Public Health Specialist - Care and Treatment	CDC	FSN	Care and Treatment
10.	Vacant	Admin Assistant	CDC	FSN	General Support
11.	Filled	Driver	CDC	FSN	General Support
12.	Filled	Driver	CDC	FSN	General Support
13.	Filled	Senior HIV Advisor	USAID	TCN PSC	Strategic Information (Core) Care and Treatment (Core) PMTCT (Core)
14.	Filled	HIV Specialist	USAID	FSN	Strategic Information (Core) KP and Stigma and Discrimination (Core)
15.	Filled	Health Systems Specialist	USAID	FSN	Commodities Security (Core)
16.	Filled	Program Budget Specialist	USAID	FSN	General Support

Acronyms and Abbreviations

ANC	Antenatal clinics
ART	Antiretroviral treatment
ARV	Antiretroviral drug
C&T	Care and treatment
CODB	Cost of doing business
DPSL	Luanda Provincial Health Directorate
EID	Early infant diagnosis
EWIs	Early Warning Indicators
FAA	Forças Armadas Angolanas
FSW	Female sex worker
FY	Fiscal year
GRA	Government of the Republic of Angola
IBBS	Integrated Biological and Behavioral Surveillance
INLS	National AIDS Institute
IP	Implementing partner
HCW	Health care worker
HIS	Health Information Systems
HRH	Human resources for health
HTC	HIV testing and counseling
KP	Key population
LFTU	Lost to follow-up
M&E	Monitoring and evaluation
MOH	Ministry of Health
MSM	Men who have sex with men
OSM	One-stop-shop-model
PAF	Patient assisted facilitator
PHDP	Positive Health, Dignity, and Prevention
PITC	Provider initiated testing and counseling
PEPFAR	President's Emergency Plan for AIDS Relief
PT	Proficiency testing
QA	Quality Assurance
QI	Quality Improvement
RDS	Respondent driven survey
SABERS	Seroprevalence and Behavioral Epidemiological Risk Survey
SADC	Southern African Development Community
SBOR	Systems Budget Optimization Review
SI	Strategic information
SID	Sustainability Index Dashboard
SIMS	Site Improvement Monitoring System
SOP	Standard operating procedure
SQA	Service quality assessment
TA	Technical assistance
TB	Tuberculosis
TWG	Technical working group
USG	U.S. Government
VL	Viral load
VCT	Voluntary counseling and testing
WHO	World Health Organization

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, KP, 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	Initiation of new patients, support groups		
Prevention	PHDP		
HSS	Lab strengthening, commodities		
KP	linkages		
Priority Population	Quality control for HIV testing		
SI	DHS+, KP size estimation, IBBS		
Totals			

APPENDIX B

B.1 Planned Spending in 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$1,963,725	\$15,736,275	\$17,700,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code				
PEPFAR Budget Code	Budget Code Description	Amount Allocated	Applied Pipeline	New Funds Needed
HBHC	Adult Care and Support	730,207	20,000	710,207
HLAB	Lab	935,000	588,105	346,895
HTXS	Adult Treatment	2,158,648		2,158,648
HVCT	Counseling and Testing	2,281,596		2,281,596
HVMS	Management & Operations	5,023,642	1,285,620	3,738,022
HVOP	Other Sexual Prevention	1,465,639		1,465,639
HVSI	Strategic Information	1,449,893	20,000	1,449,893
HVTB	TB/HIV Care	350,000		350,000
OHSS	Health Systems Strengthening	2,270,360	50,000	2,220,360
PDCS	Pediatric Care and Support	128,872		128,872
PDTX	Pediatric Treatment	906,143		906,143
TOTAL		\$17,700,000	\$1,963,725	\$15,736,275

B.2 Resource Projections

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

The chart above shows the shift of budgeted funding from COP 15 to COP 16. This shift is due to activities needed to address gaps discussed within the SBOR activities as well as funding needed to support new service delivery models as well as the implementation of Test and Start.