

ANGOLA

Country Operational Plan

COP2019

Strategic Direction Summary

7 May 2019



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Acronym List

AGYW	Adolescent Girls and Young Women
ANASO	Angolan Network of AIDS Services Organization
ANC	Antenatal Clinic
ART	Antiretroviral Treatment
ARVs	Antiretroviral
ASCAM	Associação Solidariedade Cristã e Ajuda Mutua
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CLHIV	Children Living with HIV
CODB	Cost of Doing the U.S. government's PEPFAR Business
COP	Country Operational Plan
CSO	Civil Society Organizations
DBS	Dried blood spots
DHIS ₂	District Health Information System
DOD	Department of Defense
DoS	Department of State
DQA	Data Quality Assessment
DSD	Direct Service Delivery
ECD	Early Childhood Development
EHR	Electronic Health Records
EID	Early Infant Diagnosis
EMR	Electronic Medical Record System
eMTCT	Elimination of Mother to Child Transmission
FAST	Funding Allocation to Strategy Tool
FP	Family Planning
FSW	Female Sex Workers
FOJASSIDA	Fórum Juvenil de Apoio a Saúde e prevenção da SIDA
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRA	Government of the Republic of Angola
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HMIS	Health Management Information System
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening
INE	Angolan National Institute of Statistics
INLS	Instituto Nacional de Luta Contra o SIDA (National AIDS Institute)
IP	Implementing Partner
IRIS	Associação Iris (not an acronym)
KP	Key Population
LMIS	Lab Management Information System

LGBTI	Lesbian, Gay, Bisexual, Transgender, and Intersex
LTFU	Lost to Follow-Up
M&E	Monitoring and Evaluation
MC	Male Circumcision
MCH	Maternal and Child Health
MMM	Mothers-to-Mothers Model
MMS	Multi-Month Scripting
MoD	Ministry of Defense
MoH	Ministry of Health
MSM	Men who have Sex with Men
NVP	Nevirapine
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-initiated Testing and Counseling
PLHIV	People Living with HIV
PMI	U.S. President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission
POART	PEPFAR Oversight and Accountability Response
POC	Point of Care
QA	Quality Assurance
RTK	Rapid Test Kit
SABERS	Seroprevalence and Behavioral Epidemiological Risk Survey
SCMS	Supply Chain Management System
SDS	Strategic Direction Summary
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub National Unit
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
TBD	To Be Determined
TG	Transgender people
TLD	Tenofovir Lamivudine Dolutegravir
ToT	Training of Trainers
TPT	TB Preventive Therapy
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG	U.S. Government
USDH	United States Direct Hire
VCT	Voluntary Counseling and Testing
VL	Viral Load
VLSM	Viral Load Sample Management
WHO	World Health Organization

1.0 Goal Statement

In COP19, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Angola program will shift its programming from nine facilities in Luanda and military and key populations [men who have sex with men (MSM), transgender people (TG), and female sex workers (FSW)] interventions, to a family-focused prevention of mother-to-child transmission (PMTCT) approach in four provinces including a nuanced approach for the military population. We aim to transfer the knowledge we gained working in Luanda to the government of the Republic of Angola (GRA), and we will use that knowledge to inform the technical assistance (TA) we provide around a family-focused approach to PMTCT. Historically, the GRA has struggled to implement policies to improve the HIV cascade of care for people living with HIV (PLHIV). The country's First Lady, Ana Dias Lourenço, recently signed on to the African-Union-sponsored Born Free to Shine Initiative and has since become a vocal advocate for improving HIV care in Angola. Her advocacy increased the Instituto Nacional de Luta Contra o SIDA's (INLS) (U.S. National AIDS Institute equivalent) focus on PMTCT, thereby creating a new binding site at which PEPFAR Angola will affect change and provide policy implementation TA throughout the cascade of care for PLHIV. PEPFAR Angola will also support INLS's increased efforts to identify HIV-positive women through an amplified focus on PMTCT at antenatal care (ANC) facilities across the country.

Angola has challenges with linkage to care, poor retention, low viral load (VL) suppression rates, and a lack of VL testing availability outside of Luanda. There are significant policy barriers which prevent progress toward national epidemic control, including limited implementation of test and start and an outdated antiretroviral treatment (ART) regimen. In COP19, PEPFAR Angola will use a more streamlined and integrated approach to TA, with an increased focus on system sustainability and national policy implementation building on the political will galvanized through the Born Free to Shine initiative.

We will measure success by increased functionality and sub-national level use of the already-existing data collection platforms of District Health Information Software 2 (DHIS2) and the recently updated national monitoring and evaluation (M&E) tool. Implementation of national policies at all sub-national levels in the four PEPFAR priority provinces of Benguela, Cunene, Huambo, and Lunda Sul will act as a measure of our successful TA at the national and provincial levels. The GRA recently announced that the necessary policy update for a modernized ART regimen will be in place by the end of fiscal year (FY) 2019 and PEPFAR Angola will provide TA for implementation of the new regimen at all levels throughout FY2020. We will also support expanded use of index case testing into the standard HIV cascade of care, and implementation of multi-month scripting (MMS). Working toward viral load suppression (VLS) for PLHIV outside of Luanda requires more than implementation of the necessary policies. It also requires building capacity for viral load (VL) testing by creating a specimen transport system and maximizing the national HIV laboratory's use of existing testing platforms. To be effective, new HIV policies also require availability of HIV-related commodities. In COP19, PEPFAR Angola will assist INLS with quantification, forecasting, supply chain planning, and distribution of key commodities from the national to the sub-national levels. We aim to reduce stock outs of ART and testing supplies to 15% or less in our priority provinces (currently estimated at 34%). In facilities receiving TA from PEPFAR Angola, we expect to see at least a 50% increase in HIV testing among pregnant women. We will expand targeted HIV testing by introducing index case testing into the cascade of HIV care. For each identified HIV-positive pregnant woman, we expect to test at least five additional individuals via index testing of her family. From there, we will continue index testing the sexual

partners and children, as appropriate, of the original HIV-positive pregnant woman's contacts. We aim to link all PLHIV we diagnose to ART and estimate that this could double the number of ART patients in some facilities.

As part of our strategy for sustainability, PEPFAR Angola will engage with community organizations in the catchment areas of our facilities and will train and mentor individuals in the community to become Mentor Mothers who will then mentor and assist patients through the cascade of care, thereby increasing linkage and retention. We will also work to maximize facility-community integration and by creatively implementing evidence-based interventions.

To reach these goals, PEPFAR Angola 1) decreased the number of off-shore hire positions to one US direct hire (USDH) plus 6 months of the PEPFAR Coordinator position, 2) reduced the number of clinical implementing partners (IPs) from two to one, and 3) will maximize IP efficiency by embedding personnel in provincial ministries of health.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

The Angolan Ministry of Health (MoH) is a hierarchical system consisting of three levels of health administration: national, provincial, and municipal. The national level includes Cabinets of the Minister and Secretaries of State, Support Boards, and Central Executive Boards. The provincial level is made up of Provincial Health Offices that depend administratively on provincial governments and receives methodological guidance from the national level. Financial support for implementation comes from both national and provincial budgets. At the municipal level, the Municipal Health Directorates depend on the Municipal Administration for administration issues and implementation guidance comes from the provincial and national levels. INLS is the national governing body for HIV programming; INLS is under presidential supervision but functions within the MoH system.

Angola has an estimated population of 30,175,553 inhabitants (2019 Angolan National Institute of Statistics (INE) population projection data). Life expectancy at birth in Angola is 62.2 years (2019 INE population projection), far below the global average of 81 years. Angola has the highest birth rate in the world at 43.7/1,000 people and the infant mortality rate is 65.89 deaths/1,000 live births, 10th highest globally [Center for Intelligence Agency (CIA), 2018].

Findings from the three most recent population-based HIV sero-surveillance studies, the Demographic and Health Survey (DHS), Integrated Bio-behavioral Surveillance Survey (IBBS), and the Seroprevalence and Behavioral Epidemiological Risk Survey (SABERS) confirm that the HIV/AIDS epidemic in Angola is a low-level generalized, primarily heterosexually-driven epidemic (DHS+ in 2015/2016, IBBS in 2016, and SABERS in 2015). In 2015, PEPFAR Angola partnered with the GRA to conduct the first-ever nationwide DHS+ which captured nationally representative information on health behaviors and biomarkers, including HIV testing. DHS (2016) reported an overall HIV prevalence of 2.0% among adults aged 15 to 49 years in Angola; this translates to approximately 276,000 Angolans living with HIV. Prevalence among adult females aged 15-49 years is higher than among adult males (2.6% vs. 1.2%). HIV prevalence is not evenly distributed throughout the country; HIV prevalence is 1.9% in Luanda and is equal to or exceeds four percent in three provinces: Cunene (6.1%), Cuando Cubongo (5.5%) and Moxico (4.0%). Of

all adults living with HIV, 23% are on ART; of all children living with HIV, less than 12% are on ART, according to 2019 UNAIDS Spectrum estimates.

The 2016 IBBS obtained HIV and STI prevalence and size estimates for key populations (KP), and mapped hotspots among FSW, MSM, and transgender women in selected cities. Results for Luanda indicated that HIV prevalence is 7.8% among adult FSWs and 2.4% among MSM and TG. Results from this study also include Luanda KP size estimates of 35,064 for FSWs and 26,112 for MSM.

The 2015 SABERS estimated HIV prevalence of 2.5% among military personnel. Though age distribution of participants in 5-year incremental blocks was not displayed in the SABERS, data did collect age disaggregation among military men. The median age of participants was of 35 (range 18-81) years. Given that it has been 5 years since the SABERS was conducted, and based on actual PEPFAR program data, these estimates need to be updated. Currently, the overall HIV-positivity rate (programmatic yield) among the 141,960 Armed Forces active-duty military is estimated at 3.9%. A new SABERS would allow the program to have a denominator to measure against Angolan military PLHIV programmatic reference and provide consistent epidemic information. Programmatically, the military regions with highest HIV prevalence remain the same as those revealed in the 2015 seroprevalence study: southern region (5.4%), eastern region (3.6%), central region (3.5%), and Luanda region (2.4%), thus justifying the continuation of PEPFAR support for interventions in these regions.

ANC seroprevalence surveys were conducted semi-annually from 2005 through 2013 and HIV prevalence among pregnant women was stable at 2-3% throughout the survey period. The 2013 ANC seroprevalence survey showed an overall HIV prevalence of 2.2% among women 15-49 years of age; 1.7% among women 15-24 years old. HIV prevalence is not evenly distributed throughout the country and 2013 ANC HIV prevalence among pregnant women exceeded four percent in five of 18 provinces (Benguela, Bie, Cunene, Cuando Cubongo, and Lunda Norte). HIV prevalence among pregnant women living in urban areas was higher (2.6%) compared with those living in rural areas (2%). According to DHS data, only 37% of women with a live birth in the 2 years preceding the survey were counseled and tested for HIV and received their test results. DHS 2016 also revealed that less than half of all pregnant women needing HIV treatment to prevent mother-to-child transmission (MTCT) receive ART. Angola's MTCT rate is 21%, the second highest in the world according to the UNAIDS 2017 estimate; in 2018 INLS estimated MTCT at over 26%.

Angola is among the 22 highest TB burden countries in the world, and one of the highest TB burden African countries. In 2018, 70,362 cases of TB were registered in Angola and 44,998 TB patients were tested for HIV, for a testing rate of 64% of TB patients. Of those tested, 4,327 were HIV positive, for a positivity rate of 9.6%. Coinfection rates ranged from 3% in Kuanza Norte, Huila, and Malange to 36% in Cunene.

According to 2019 Spectrum estimates for Angola, 28,316 people were newly infected with HIV and 13,465 deaths were attributable to HIV. The AIDS-related mortality figure is likely largely underreported, due to constraints with mortality reporting across all causes. Table 2.1.2 (below) shows the cascade of HIV diagnosis, care, and treatment in Angola with an estimated total population ART coverage of 28% and viral suppression rate of 6%. Due to the lack of a national adult HIV notification system, PEPFAR data was used for reporting HIV testing and linkage to ART. In 2017, INLS reported performing a total of 1,215,646 HIV tests, of which 3.3% were positive.

Positive test yield was highest in adults >15 years (4.5%), followed by children <15 years (3.5%), and lowest among pregnant women (1.6%). Of those identified as HIV-positive, 18,586 initiated ART, of which 17,149 (92%) were adults and 1,437 (7%) were children.

Table 2.1.1: Host Country Government Results

	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	3,015,992	100	6,842,428	23	6,903,021	23	3,066,250	10	3,062,493	10	5,290,808	18	4,988,993	16	Spectrum, 2019
HIV Prevalence (%)															Spectrum, 2019
AIDS Deaths (yearly)	13,465		2,567		2,622		545		266		5,067		2,398		Spectrum, 2019
# PLHIV	351,415	100	21,353	6	21,690	6	37,009	11	11,147	3	175,284	50	84,933	24	Spectrum, 2019
Incidence Rate (Yr)		0.98		1.4		1.4		2.9		1.1		2.7		1.4	Spectrum, 2019
New Infections (Yr)	28,316														Spectrum, 2019
Annual births	1,282,991	100													Spectrum, 2019
% of Pregnant Women with at least 1 ANC visit		82	--	--			--	--			--	--			DHS, 2016
Pregnant women needing ARVs	25,623														Spectrum, 2019
Orphans	242,929		--		--		--		--		--		--		Spectrum, 2019
Notified TB cases (Yr)	70,362		--		--		--		--		--		--		TB Program data, 2018
% of TB cases that are HIV infected	4,327	9.6	--	--	--	--	--	--	--	--	--	--	--	--	TB Program data, 2018
Circumcised Males	5,684*	96			--	--			2,489*	95			--	--	DHS, 2016; *# of males surveyed, not national total
MSM Population (est.)	29,000	13													Place Study, 2016 (5 provinces)
MSM HIV Prevalence	1,016	1.9													Place Study, 2016 (5 provinces)
FSW Population (est.)	54,200	1.8													Place Study, 2016 (5 provinces)
FSW HIV Prevalence	1,879	7.8%					--	--			--	--			Place Study, 2016 (5 provinces)
PWID Population (est.)	unknown	--													
PWID HIV Prevalence	unknown	--													
Estimated Size of Priority Population & HIV Prevalence (military)	141,960	3.9	NA	-	NA	-	1,704	3.4	37,179	2.7	2,555	6.6	100,522	7.3	MoD Health Division 2017 Census; PEPFAR 2018 Program Data

Table 2.1.2: 90-90-90 Cascade—HIV Diagnosis, Treatment and Viral Suppression

Table 2.1.2: 90-90-90 Cascade—HIV Diagnosis, Treatment and Viral Suppression										
Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year			
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	30,153,992*	1.95** (15-49)	351,415*	135,745*	101,861	28.99	67 (2018)	161,366	11,960****	7,251****
Population <14 years	3,765,554~	--	14,604*	4,308*	2,226*	16.74* (0-4)	--	3,366 (1-9years)	176**** (1-9years)	108**** (1-9years)
Men 15-24 years	3,062,493*	0.36*	11,147*	10,665*	1,812*	17.58*	59 ****	12,421	370****	150****
Men 25+ years	4,988,993*	-	--	--	27,634*	43.49. *	70 ****	36,487	3,272****	2,312****
Women 15-24 years	3,066,250*	1.21*	37,008*	363,80*	4,068*	10.69*	47.85****	33,505	1,110****	542****
Women 25+ years	5,290,808*	--	--	--	61,027*	46.75*	66****	58,297	5,939****	3,566****
MSM°	29,000 (5 provinces)	1.9***	462 (Luanda)	288	241	84%	66%	3,746	1,744	152
FSW°	51,200°	7.8***	2,542	1,632	1,279	78%	69%	16,609	1,034	904
TG°	3,320	9***	272	36	26	72%	--	35	13	9
Military#	141,960	3.9%	5,537	3,821	4,092	77%	62%	13,553	952	918

*Spectrum, 2018

^ DHS, 2016

Sources: *Spectrum, 2018 and 2019 |~ National Institute of Statistics projections, 2019 | ** DHS2016 | *** Surveys (PLACE study 2016 in 5 provinces of Angola; SABERS 2016) | **** PEPFAR Panorama FY18 | #Angola FY18Q4 POART. Note: At the column “HIV Testing and Linkage to ART within the Last Year 2018”, total and sub-population contains data only from PEPFAR Q2FY18 period when finer disaggregates was rolled out. Data accounts for the period of Q2FY18-Q1FY19. Results in the total population, includes unknown sex.

Figure 2.1.3 National and PEPFAR Trend for Individuals Currently on Treatment

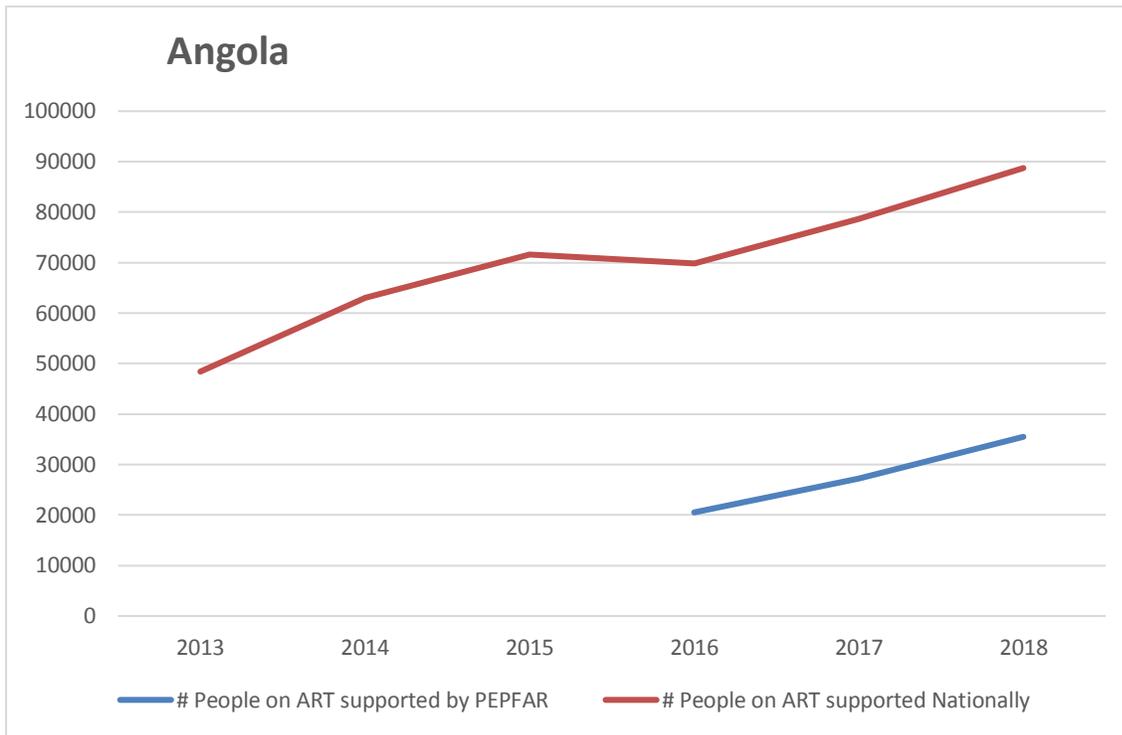
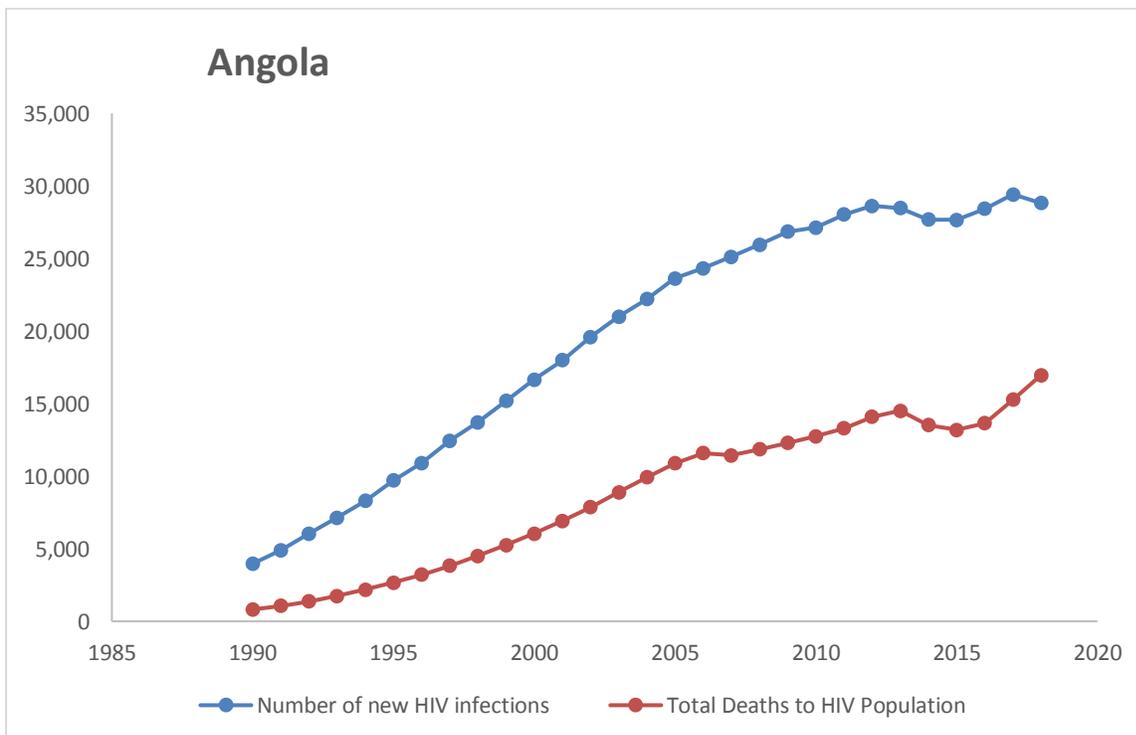


Figure 2.1.4 Trend of New Infections and All-Cause Mortality in PLHIV



2.2 Investment Profile

Angola recorded the fastest economic growth worldwide in the past decade; it is the largest oil producer in sub-Saharan Africa, and Africa's third-largest economy. Angola's estimated GDP was \$193.6 billion in 2017, which ranks 160 of 228 countries in gross domestic product per capita (CIA, 2019). Its economy is driven by the oil industry; 90% of Angola's exports are oil and oil accounts for more than 70% of government revenue (CIA, 2019). Therefore, the country's once-booming economy was significantly adversely affected by the worldwide drop in oil prices over the past few years. The global reduction in oil prices since 2014 forced the Angolan government to revise its national budget downwards in previous years, including in 2018, but the economy is slowly recovering. A lack of foreign exchange in the local market, exacerbated by a loss of U.S. correspondent banking relationships for dollar transactions, has contributed to business closures, lack of medical supplies, and a sharp drop in overall imports. This financial environment led the previous GRA administration to prioritize government operational and defense spending over social spending.

The current presidential administration is increasing funding for health. President João Lourenço increased the health portion of the national budget from 3.5% to just over 7% in the 2019 budget, which translates to \$400 million being allocated to the MoH, but the amount disbursed to MoH will likely be significantly less. Despite current investments, the deficits created by decades without government support for the health sector will persist into the foreseeable future and will continue to contribute to periodic health crises. The historically limited national health budget restricted development of administrators and health professionals, leading to a critical lack of human capacity across the MoH. That lack of human capacity at all MoH levels complicates the process of transferring current PEPFAR programs and knowledge to the GRA.

Since 2007, PEPFAR has invested \$130,966,144 million to support the GRA's fight against HIV. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) committed \$87 million toward HIV-related commodities and programming from 2016 to 2018 and \$58 million from 2018 to 2021. In 2018, the Global Fund reduced its total HIV investment in Angola and shifted its focus toward PMTCT programming, though they will continue to supply 40% of the forecasted ART and HIV rapid-test kit (RTK) needs in Angola. The GRA committed to funding the remaining 60% of ART and RTKs needed, but it appears that the GRA will not be able to meet that commitment in FY19. Similar to PEPFAR, the Global Fund saw the First Lady's Born Free to Shine initiative as a promising step toward changing HIV care and treatment in Angola. UNAIDS also sees Born Free to Shine as a proof of the GRA moving toward a more active role in decreasing the impact of HIV in their country; both organizations are actively supporting the First Lady's initiative. During COP19, in addition to PMTCT, the GF program will focus on HIV prevention (including KPs: truck drivers, miners, MSM, TG, and FSWs), treatment, care, and support for the general HIV-positive population; health information system strengthening; and TB/HIV co-infection.

Table 2.2.1: Annual Investment Profile by Program Area					
Program Area	Total Expenditure	\$ PEPFAR*	\$ GF	% Host Country	% Other
Clinical care, treatment and support		845,707 [^]	4,269,510		n/a
Community-based care, treatment, and support		Included in PMTCT	Included in PMTCT		n/a
PMTCT		582,909	975,456 ⁶	7%	n/a
HTS		295,820	226,202	--	n/a
Priority population prevention	n/a	n/a	68,219	--	n/a
AGYW Prevention	n/a	--	273,583	--	n/a
Key population prevention	n/a	n/a	180,097	--	n/a
OVC	n/a	n/a	Not included	--	n/a
Laboratory	n/a	168,429	Not included	--	n/a
SI, Surveys and Surveillance	n/a	366,828	Not included	--	n/a
HSS	n/a	2,190,226	339,704	--	n/a
Total			6,332,771.00	--	n/a

* PEPFAR for new funding only

[^] Includes TB

Table 2.2.2: Annual Procurement Profile for Key Commodities					
Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	90%	n/a	~30%*	60%	
Rapid test kits	100%	n/a	40%	60%	
Other drugs	n/a	n/a	n/a	n/a	
Lab reagents	100%	n/a	40%	60%	
Condoms	\$400,000	20%		40%	40% (Condom fund)
Viral Load commodities			40%	60%	
VMMC kits	n/a	n/a	n/a	n/a	n/a
MAT	n/a	n/a	n/a	n/a	n/a
Other commodities	n/a	n/a	n/a	n/a	n/a
Total					

*Total to be procured: 33,858 (1-Jul-19 to 30-Jun-20)

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
DREAMS Innovation	n/a	n/a	n/a	n/a	n/a	
VMMC – Central Funds	n/a	n/a	n/a	n/a	n/a	
Other PEPFAR Central Initiatives	n/a	n/a	n/a	n/a	n/a	
Other Public Private Partnership	n/a	n/a	n/a	n/a	n/a	
Total	\$o	\$o	\$o	\$o	\$o	

Table 2.2.3: Annual 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
USAID MCH	n/a	n/a	n/a	n/a	
USAID TB	n/a	n/a	n/a	n/a	
USAID Malaria	\$20,000,000	\$5,585,000	1	\$688,504	Supply chain TA
Family Planning	\$2,000,000	\$850,000	1		
NIH	n/a	n/a	n/a	n/a	
CDC (Global Health Security)	n/a	n/a	n/a	n/a	
Peace Corps	n/a	n/a	n/a	n/a	
DOD Ebola	\$55,445	\$o	\$o	\$o	Preparedness and response emergency training to MoH and MoD health workers focused on Ebola & other hemorrhagic diseases outbreak response
MCC	n/a	n/a	n/a	n/a	
Total	\$22,055,445	\$6,435,000		\$688,504	

2.3 National Sustainability Profile Update

Angola achieved a peaceful transition of government in 2017 when João Lourenço was elected President, ending the 38-year term of the previous president. Although the current administration is quickly moving away from the governing methods of the former regime, Angola has a lot of progress to make after 27 years of civil war followed by 15 postwar years of the government investing relatively little of its oil sector wealth into health, education, and social services for its citizens.

The 2018 Angola Sustainability and Index Dashboard (SID) exercise resulted in a slight downgrade (7.8 to 7.4 points) for policies and governance. Some of Angola’s existing policies that enable

sustainability include the National Child Protection Commitment, the Law for HIV/AIDS 8/04, the HIV Treatment Protocol for Stable Patients, and the National Council for Social Action, and the Ministerial Decree (11/8 of 2011) on task-shifting of doctors/nurses that allowed nurses to dispense ARVs at small healthcare facilities that lack physicians. Licensed clinical nurses may dispense ARVs at all sites except national hospitals; unfortunately, however, there are very few licensed nurses in the public health facilities. Angola would need a threefold increase in nursing staff just to reach the global average nurse density (1.03 nurses/1,000 Angola citizens vs. 3.14 nurses/1,000 people globally); the physician workforce in Angola (0.1 physician/1,000 people) is also extremely small compared to the global average physician density (1.03 physicians/1,000 people) (MoH 2018 data compared to WHO global averages). Currently, there is no policy permitting ARV dispensing at the community level. There is also a new penal code prohibiting discrimination based on sexual orientation however there are no specific policies for the protection of orphans and vulnerable children. Even though financial audits are regularly conducted, results are not publicly available without obtaining government approval via a written request.

Policy barriers continue to prevent progress towards reaching HIV epidemic control at the national level. As of February 2019, a policy to modernize the first-line ART regimens was approved but does not include TLD; self-testing was approved for a highly regulated pilot project in KPs, but there is no consideration for implementing self-testing in the general population in the near future; and MMS of ART is acceptable at the policy level but not currently implemented due to commodities concerns from INLS. Though the policy environment in Angola currently complicates acceleration towards epidemic control, we anticipate that the combination of political will from the First Lady and better focused and more efficiently implemented TA from PEPFAR Angola will create an environment more conducive to national efforts toward achieving epidemic control.

The current environment for local partnerships with civil society and the private sector is limited. The 2018 Angola SID scored a low “yellow” (emerging sustainability and needs some investment) for civil society engagement. The SID noted that while formal channels for civil society organization (CSO) engagement exist, including annual planning and program reviews, policy development and involvement in surveys, CSOs do not have substantial impact on financial decisions related to HIV. Furthermore, while civil society members occupy strategic positions such as Vice President of the Global Fund Subvention Mechanism (MCN) and Coordinator of the MCN Strategic Supervisory Committee, impact of these roles are not significant due to limited resources.

While Angola’s SID score for private sector engagement increased from 1.6 in 2015 to 3.6 in 2017, it is still within the “red” (unsustainable and requires significant investment) range. The increase in score is mainly due to having a legal framework for the private health sector and having a standardized process for developing public-private partnerships with regulations for private providers to adhere to the national ART guidelines. The private sector (represented by Chevron) is part of the GF’s Country Coordinating Mechanism Executive Committee. The red SID score shows that there is still limited private public partnership engagement.

2.4 Alignment of PEPFAR Investments Geographically to the Disease Burden

PEPFAR Angola is moving its focus from key and priority populations at nine facilities in Luanda in COP18 to four provinces plus the military population in COP19. In order to align PEPFAR

investments with Angola's disease burden, we overlaid population density with HIV burden at the provincial level. In the first phase of implementation, PEPFAR Angola will provide TA to Benguela, Cunene, Huambo, and Lunda Sul; the second phase will focus on Cuanza Sul, Huila, and Moxico; with the third phase including Bie, Cuando Cubango, and Lunda Norte. Program implementation in the first phase will take one year to achieve success, as measured by all of the facilities receiving TA fully implementing all national HIV policies and producing timely and accurate DHIS2 reporting. Subsequent phases would likely take less time to achieve success, but implementation speed will depend on funding constraints. During all phases, PEPFAR Angola will continue to provide national-level TA. After determining the provinces, PEPFAR focused on utilizing program data, extracted from DHIS2, to identify municipalities. In the municipalities with highest testing volumes and HIV positivity rates, program data was again used to prioritize facilities. Figure 2.4.1 below shows data supporting our geographic investments.

In support of this geographic shift, and in addition to routine COP18 program activities, PEPFAR Angola will assist the MoH and staff at the PEPFAR-supported facilities to transition all facility-level assistance PEPFAR provides to MoH staff. In order to mitigate the facility-level disruption caused by geographic refocusing, PEPFAR Angola informed INLS of COP18 program transition plans in early February 2019 and updated them as timelines and planning were modified. Ongoing work with facility leadership to map where PEPFAR has been providing support and to plan how each facility can absorb that work has been a part of the post-Johannesburg discussions since March 2019. At the request of INLS, PEPFAR Angola is creating a toolkit of job aids and standard operating procedures (SOPs) based on the recently updated national policies (test and start, MMS, index testing, and ART guidelines) and best practices developed while working in Luanda (facility- and community-based index case testing, patient navigators to increase retention, M&E tools, TB testing and TPT algorithms, patient tracking forms, clinic flows, key messages for HIV counseling, index case testing, and One Stop Shop for HIV/TB co-infected patients). The PEPFAR team will also create training of trainers (ToT) curricula to compliment the toolkit. PEPFAR Angola will use the toolkit and ToT curricula to facilitate a final training push in the nine Luanda facilities to solidify the best practices from the past three years with PEPFAR's support. INLS will use the toolkit and ToT curricula to roll out their updated HIV testing, care, and treatment guidelines later this year. In COP19, PEPFAR Angola will use the toolkit and curricula in the 17 new facilities in four provinces where we will implement family-focused PMTCT.

Current program data from the Ministry of Defense (MoD) supports the results from the 2015 SABERS. The military regions with the highest HIV prevalence are the southern region (5.4%), eastern region (3.6%), central region (3.5%), and Luanda region (2.4%). PEPFAR Angola will continue to support military-focused HIV programming in the regions shown in the map below.

ANGOLA: HIV Prevalence by Military Region.

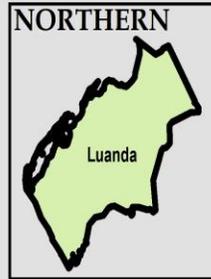
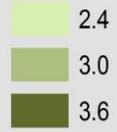
DRAFT

SENSITIVE
BUT
UNCLASSIFIED

 Military Regions

 Provinces

HIV Prevalence

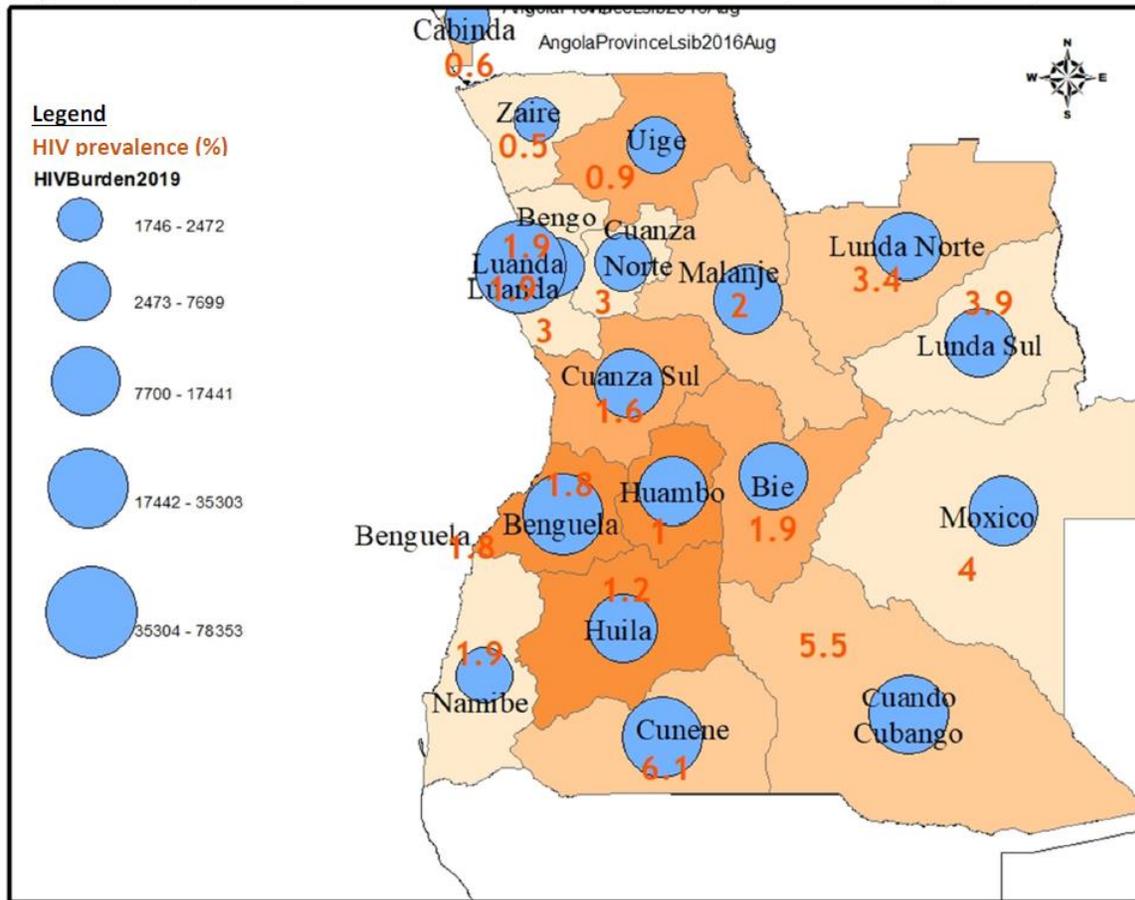


Sources:

MAPSINFO.ppt
(Powerpoint file)
Provided on 3-2-2016

Names and boundary
representation are
not necessarily authoritative.

Figure 2.4.1: Projected Population, Total PLHIV, and HIV Prevalence by Province, Angola, 2019



2.5 Stakeholder Engagement

PEPFAR Angola held a Stakeholders' Engagement meeting on January 29th, 2019 at INLS. Representatives from INLS, UNDP, Global Fund, UNAIDS, UNICEF, and multiple CSOs participated in the meeting. We presented our COP19 strategy and requirements of the planning level letter (PLL) as they were at the time. When we returned from the in-person COP19 meeting with a new direction, we reengaged with all of our stakeholders to update them about our new family-focused PMTCT approach.

Host country government: The MoH has been very engaged in the COP19 planning process and participated in joint PEPFAR site visits to Cunene (November 2019) and Benguela (March 2019). The Minister of Health, Director of INLS, and Director of the National Public Health Reference Laboratory were highly engaged in planning for COP19 during our in-person COP19 meeting in March 2019. After the meeting in Johannesburg, we continued our close engagement with INLS via email and in-person conversations, exchanging data, and hosting a two-day planning retreat with representatives from INLS, MCH, Benguela province, and Huambo province. During the planning retreat, we visited one of our future facilities for TA and discussed patient flows and gaps in care and data collection with the facility staff, the INLS Director, and the Provincial Health Director. Over the course of our meetings with INLS, we further outlined and agreed on areas of TA for COP19. Broadly speaking, INLS wants to develop their data collection systems for facility data and laboratory data; wants help to expand test and start with fidelity and monitor its implementation; is looking toward TLD transition and will rely on PEPFAR support after the WHO guidelines are finalized; and is interested in community-based solutions to testing and retention, but are not sure how to use their limited resources most wisely. In May 2019, PEPFAR Angola plans to meet with the directors of the nine currently PEPFAR-supported facilities, the Luanda Provincial Health Director, the HIV Focal Point, and INLS staff to elaborate on the transition plan out of the Luanda facilities.

Global Fund and other multilateral donors: PEPFAR Angola met with Global Fund multiple times in the past few months to discuss areas for collaboration such as PMTCT, DHIS-2, open laboratory management information system (LMIS), national level TA/trainings, and supply chain management. We also discussed our mutual concerns about gaps in programming caused PEPFAR Angola's new direction. Both organizations see new gaps in KP programming (\$2 million), condoms (\$400k), and viral load reagents (\$400k). Unfortunately, budgets for the coming FY lack the necessary flexibility to fill those gaps, but Global Fund and PEPFAR Angola committed to looking for private sector or domestic funding to help Angola fill those gaps

Civil Society: Six CSOs [ANASO, Mwenho, Cuidados de Infância, ASCAM, FOJASSIDA, and LGBTI KP-led organizations (IRIS)] were invited to the PEPFAR Stakeholders' Engagement meeting on January 29, 2019. In addition to the strategic direction for COP19, PEPFAR Angola presented FY18 results, discussed successes, and identified gaps in programming. Based on that information, COP19 activities were developed with full CSO engagement in all areas of PEPFAR programming. However, PEPFAR Angola's strategic direction changed during the in-person COP19 Johannesburg meeting in March 2019. CSOs were informed of the changes on April 2, 2019 and prepared a letter in response that is included in our COP19 submission. Internally, CSOs analyze programmatic data on a weekly basis for decision-making and engage in weekly CSO coordination meetings with ANASO, the Angolan HIV/AIDS CSO umbrella organization, as well as the CSO forum on HIV, Malaria, and TB. These regular coordination meetings will continue without PEPFAR support in COP19.

Private Sector: PEPFAR Angola is discussing possible collaborations with Chevron around PMTCT programming and UNITEL, the telecommunications and cellular service provider in Angola, around creative ways to sustain data collection and patient retention in care in support of the First Lady's PMTCT initiative.

There is still limited public-private partnership engagement in Angola. There is no active participation from the private sector on policy and budget planning for HIV. Historically, the GRA relied on a consortium of approximately six businesses (CEC) as its main interlocutors. Unfortunately, CEC has become inactive due to the majority of its member companies downsizing in the wake of the economic downturn and eliminating many Corporate Social Responsibility (CSR) departments. PEPFAR Angola is prioritizing efforts to create new approaches to private-sector engagement with companies that have shown a strong commitment to social responsibility, like UNITEL.

3.0 Geographic and Population Prioritization

Ana Dias Lourenço, Angola's First Lady, recently signed on to the African-Union-sponsored Born Free to Shine initiative. Born Free to Shine is focused on eliminating mother to child transmission of HIV and increasing child and maternal health. PEPFAR Angola will use the First Lady's initiative as a binding site to affect change to the entire HIV cascade of care. That programmatic emphasis necessitates a family-focused PMTCT approach that will rely on finding and treating pregnant women living with HIV, testing and treating all their children and sexual partners, and then testing the partners' sexual partners. We estimate that this model will enable us to eventually reach nearly all PLHIV in Angola, and in the process assist the MoH with updating the entire HIV cascade of care. In COP19, we expect to see at least a 50% increase in HIV testing of pregnant women in the ANC facilities where we provide TA. Index case testing is not happening outside of the nine facilities in Luanda currently supported by PEPFAR; however, by the end of COP19, index case testing will be part of routine HIV program implementation in all four PEPFAR supported provinces and facilities will be well equipped to care for a potential doubling of HIV-positive patients at the smaller facilities. If our family-focused PMTCT approach is successful, we will implement it in the proposed phase two provinces, followed by the phase three provinces. We anticipate continuing to provide "light touch" TA in the phase one provinces through COP20 in order to reach saturation of ANC facilities, strengthen the link between facility and community testing and treatment, and ensure technical capacity for M&E at provincial and facility levels.

In order to align PEPFAR investments with Angola's disease burden and political will from the First Lady's Born Free to Shine initiative, after we overlaid population density with HIV burden at the provincial level, we considered ANC coverage and total fertility rates. Based on these data-driven selection criteria and considering GRA desires, we prioritized provinces to receive focused TA from PEPFAR. After we determined the provinces to focus on, we used program data, extracted from DHIS2, to understand which municipalities had the highest volume of pregnant women seen at ANCs and the highest HIV-positivity rates in pregnant women. We chose the single high-volume municipality with the highest yield in Cunene, Huambo, and Lunda Sul. We choose two municipalities in Benguela because the yields were similarly high, the municipalities are geographically close, and are much smaller than municipalities in the other provinces. We again used program data to prioritize facilities as our primary and secondary foci of TA, based on facility volume and HIV-positivity rate. We will give 60% of our facility level TA to 5 primary facilities, one in each of the focal municipalities; the remaining 40% of facility-level TA will be

spread over our secondary focus high volume, high yield facilities. We will provide facility-level TA to a total of 17 facilities in five municipalities and four provinces. Figure 3.1 illustrates the second tier of data considerations for our provincial prioritization.

Analyses of SABERS 2015 and Site Improvement through Monitoring System (SIMS) 2018 data supports PEPFAR Angola’s continued work with the Ministry of Defense (MoD) on HIV strategies, policies, and activity planning. We will use that work to strengthen improvements made on the HIV service delivery models in the 15 priority sites PEPFAR is currently supporting in the four highest-prevalence military regions, spanning eight provinces. Our work with the MoD will continue to reduce the number of new HIV infections and other sexually transmitted infections among members of the Angolan military, their families, and surrounding civilian communities served by the military health directorate.

Key Populations

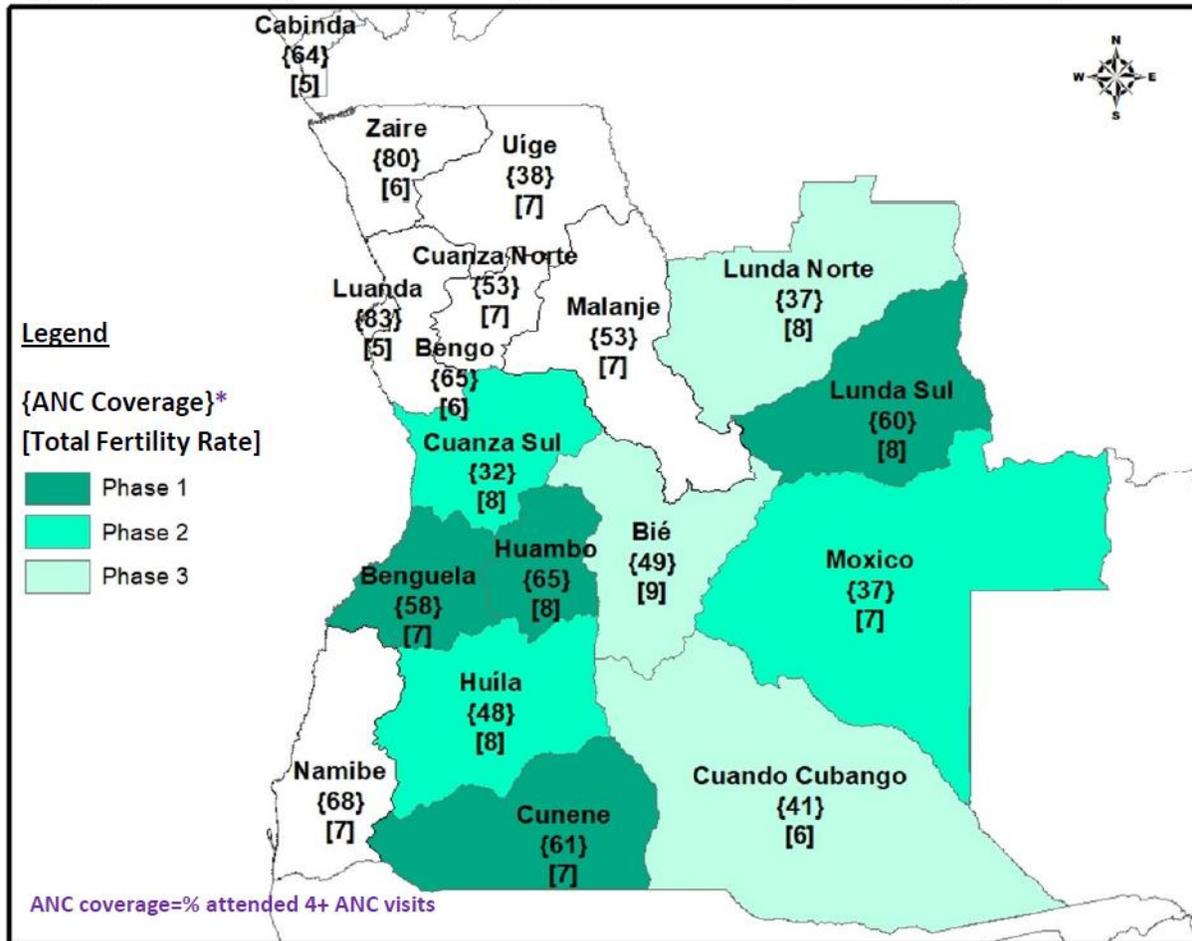
During our in-person COP19 planning meeting, PEPFAR Angola was instructed by OGAC to stop funding KP programs. This PEPFAR shift will create a gap in TA for KP-focused national policies and will significantly reduce KP programming at the community level by reducing support to civil society, community-based, and KP-led organizations.

During COP18, the PEPFAR Angola KP program was focused in Luanda, which enabled the Global Fund (2018-2022), and Chevron to support KP programming in other provinces based on data collected in the PEPFAR-supported KP IBBS, size estimation, and hotspot mapping exercise. Chevron is currently funding KP activities in Cabinda province and the Global Fund, through UNDP as the prime recipient, funds KP activities in Luanda, Bie, and Benguela provinces. PEPFAR Angola is advocating with Chevron and UNDP to directly fund the CSOs and community-based organizations (CBOs) that were supported by sub-contracts with PEPFAR Angola’s KP IP in COP18. From the start of our KP programming, PEPFAR Angola worked toward building capacity in the organizations serving KPs in Angola. Part of our last push toward sustainability is developing documents and trainings to pass our lessons learned to other KP-focused organizations.

Table 3.1 Current Status of ART saturation				
Prioritization Area	Total PLHIV/% of all PLHIV for COP19	# Current on ART (FY18)	# of SNU COP18 (FY19)	# of SNU COP19 (FY20)
Attained	n/a	n/a	n/a	n/a
Scale-up Saturation	n/a	n/a	n/a	n/a
Scale-up Aggressive	5,536/3.9%	7,702	4 military regions (15 sites)	4 military regions (15 sites)
Sustained	n/a	n/a	n/a	n/a
Central Support	86,523/26%*	83,656*	1	4

* Spectrum estimate, 2019

Figure 3.1: Non-HIV Key Indicators for Geographic Prioritization by Province, Angola, 2019



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

4.1 Finding the Missing, Getting them on Treatment, and Retaining them Ensuring Viral Suppression

According to DHS data, less than half of the women who report for at least 1 ANC visit are tested for HIV and know their status. We will ensure that all pregnant women seen in PEPFAR priority facilities know their HIV status. In order to make 100% testing of pregnant women a reality, our TA will be aimed at filling gaps in supply chain quantification and procurement so HIV tests are consistently available in facilities, quality assurance (QA) for testing in the form of training testers and performing regular QA checks, and human resources for health (HRH) training to increase testing capacity and simplify patient flows in facilities. We will also incorporate trainings, SOPs, and job aids as part of the standard clinical care package at each facility.

PEPFAR Angola will provide TA for implementing family-based Index Case Testing and Tracing (ICTT) for all HIV-positive pregnant women identified. In two provinces, Cunene and Lunda Sul, we will provide community-based TA for index case testing with a community-based counselor tracing partner(s) and children of HIV-positive pregnant women identified at the facility. The community counselors will offer community-based counseling and testing and will link PLHIV to treatment in a facility. In the other two provinces, Benguela and Huambo, index case testing TA will be initiated out of the facilities and carried into the community whenever necessary and will leverage the toolkit and ToT curricula developed from PEPFAR best practices in Luanda. In all four provinces, PEPFAR Angola will focus on testing children and sexual partners of pregnant women who test HIV positive. As we identify additional PLHIV, we will implement another round of index case testing with all sexual partners of the PLHIV found through the first index testing. We will use best practices and lessons learned from our previous FSW-focused work in Luanda to craft appropriate messaging about index case testing for high-risk pregnant women.

The facility-based healthcare workers responsible for index case testing will also track and follow up with patients who initiate ART to ensure retention in care and ultimately VLS. In the Cunene and Lunda Sul communities, we will implement the Mothers-to-Mothers Model (MMM) to provide integrated services along the continuum of care, including one-on-one education, psychosocial support, support groups, adherence assessments, and retention support. By implementing index case testing with fidelity, we will reach all ages and genders and truly provide family-focused PMTCT.

Angola recently implemented Test and Start in three provinces, including Cunene and Benguela. PEPFAR Angola will provide TA in the form of HRH training and mentoring to increase implementation of that policy in Cunene and Benguela and will assist MoH with the necessary trainings to implement the policy in Lunda Sul and Huambo, so that all PLHIV in these provinces can begin ART as soon as they are diagnosed. Both our community- and facility-based TA will include lessons learned in Luanda, such as patient contact forms and patient navigators, to improve retention in care, so that PLHIV remain on ART for life.

National- and provincial-level supply chain TA will play a vital role in ensuring stocks of ARVs are sufficient to maintain PLHIV on treatment and transition to the newly approved MMS policy. Supply chain TA and training will also assist the MoH with transitioning to TLD as the first-line treatment option after the updated WHO guidance is released later this year. PEPFAR will focus its TA and training on the use of updated tools and SOPs for forecasting, planning and distribution at national and sub-national levels, as well as inventory and pharmacy management at facility and provincial levels. In addition, PEPFAR will support the implementation of electronic Logistic and Management systems at national, provincial, and facility levels.

In alignment with the national HIV program, the MoD committed to implementing test and start in all 11 military care and treatment facilities. Based on program data from COP 17 and COP18, at least 90% of all Angolan military active duty personnel who are diagnosed with HIV in PEPFAR supported sites are successfully linked to treatment.

During COP19, the portion of our program focused on Angola's military population will continue to focus on the four military regions with the highest HIV prevalence (Southern, Eastern, Central, and Luanda regions). We will also strengthen military implementation of national HIV policies and guidelines, adapted to the military context, throughout the HIV cascade of care. At the facility level, will work to ensure active-duty PLHIV receive quality HIV-related services and

monitor for and mitigate HIV status-based stigma and discrimination. We will also evaluate programming in Luanda and gradually transition out of facility-level work in there and into above-site TA.

PEPFAR Angola will likewise use index case testing as the primary HIV testing strategy and will also employ provider-initiated testing, VTC co-located facilities, and inpatient testing in the military medical structures and brigades. PEPFAR Angola will provide a package of HIV prevention services to every individual that receives an HIV test and results. Due to the lower positivity yield in comparison to other testing modalities, we will not support mobile testing in COP19.

The recent expansion of test and start enabled the military to maintain 85% of military PLHIV on treatment. PEPFAR Angola will continue to support VL monitoring to ensure at least 80% of active-duty PLHIV on ART at military facilities have appropriate VL testing, and 85% of those with VL test results are virally suppressed. In order to make VL testing possible, the military must build plasma and DBS VL testing capacity and reinforce the existing quality assurance systems. PEPFAR Angola will assist the military with training HRH to appropriately request and properly perform VL testing, implementing regular quality assurance panels for VL testing, and developing a transport system for DBS samples.

The Angolan military HIV program sees great value in the national Born Free to Shine initiative, but their healthcare system is not designed for direct support of the initiative. Military health facilities in Angola have not integrated maternal and child health (MCH) services into their package of medical care. Women requiring family planning, PMTCT services, antenatal care, labor and delivery, or post-partum care are referred to neighboring civilian health facilities. Moreover, the military does not provide any pediatric care. In order to support the First Lady's initiative, the military healthcare program will ensure index case testing for all HIV-positive pregnant women they encounter. Given that the PEPFAR family-focused PMTCT strategy, provincial overlap with occur in two Angolan military regions with DOD program presence, specifically in Huambo and Luanda Sul. In overlapping provinces, pregnant women and their civilian contacts will be referred to civilian PEPFAR-supported facilities for ART, rather than being initiated on ART at first contact within military facilities where they cannot receive treatment. PEPFAR Angola will support a Military-Civilian Connector to ensure that pregnant women are connected to ANC care, where both the woman and her HIV-positive children/partners will be initiated, treated, and remain on ART.

After discussion with PEPFAR Angola, the MoD became concerned about the significant number of missed opportunities for PMTCT in pregnant women living in isolated communities with a military presence in Lunda Sul. The MoD committed to continuing to offer HIV screening services to high-risk women in these remote areas, and in COP19, the Angola MoD will permit HIV-positive pregnant women to initiate ART at diagnosis within the military facility. The women will eventually be transferred to the nearest civilian facility for continued care and treatment.

4.2 Prevention, Specifically for Priority Programming

PEPFAR Angola will disseminate an anti-stigma, anti-discrimination package, specifically designed for the military, including psychosocial support, nutritional counseling, policy advocacy, violence prevention, and career promotion liability to all military settings. Furthermore, a minimum package of HIV prevention services will be delivered to military personnel, family

members of military personnel, civilian employees at military bases, and civilians in the communities surrounding the military bases.

4.3 Additional Country-Specific Priorities Listed in the Planning Level Letter

During the in-person COP meeting in Johannesburg in March 2019, PEPFAR Angola was directed to consider our PLL null and void except for the \$10 million funding ceiling. The team was given verbal direction to transition all KP and facility work in Luanda to the MoH by the end of FY 2019 and to create a PMTCT focused program to support the First Lady's Born Free to Shine initiative for COP19. PEPFAR Angola was also directed to find creative ways to leverage the political will generated by the First Lady to create lasting change in the full HIV cascade of care from birth to death in females and males. By design, that streamlined focus necessitates working toward implementation of key policy across the nation and using the knowledge gained while working in the nine Luanda facilities to inform the redesigned facility-level TA for less developed provinces. PEPFAR Angola maintained its investment in programming for the military population and added a PMTCT focus to its military engagement. The organizational structure of PEPFAR Angola was also modified when the PLL was verbally re-drafted indicating that CDC serve as the clinical and technical lead agency moving forward for PEPFAR Angola.

In addition to providing TA at facilities and in communities around family-focused PMTCT, PEPFAR Angola will provide national and provincial level TA to assist INLS with implementation of key policies to modernize Angola's HIV cascade of care. As indicated in section 2.1, Angola is among the 22 highest TB burden countries in the world, and one of the highest TB burden African countries. PEPFAR Angola TA around comprehensive HIV clinical care will include promoting TB diagnostic testing and increased implementation of national TPT guidelines. TB testing and TPT algorithms and experience from the One Stop Shop for HIV/TB co-infected patients are included in the toolkit of job aids and SOPs PEPFAR Angola is currently developing based on best practices in Luanda. PEPFAR Angola will use the toolkit and ToT curriculum, inclusive of TB and TPT elements, in the 17 new facilities implementing family-focused PMTCT.

PEPFAR Angola will provide health information system TA and financial support for training and supervision for test and start expansion, especially in the four PEPFAR priority provinces. Full implementation of test and start is necessary for PEPFAR Angola to meet its targets and fulfill the minimum program requirements.

ART regimen optimization is a priority for PEPFAR and INLS. Angola will move toward implementation of TLD as the first-line ART of choice when WHO updates the international treatment guidelines. PEPFAR Angola will assist INLS with updating the national ART guidelines to include TLD, developing an ART regimen transition plan, quantifying and forecasting for TLD, and training and mentoring of clinicians who will prescribe the new regimen (see 4.4 for additional information). INLS expects to share their transition plan for further refinement by June 2019.

Implementation of the MMS policy is stalled due to ART stock constraints secondary to a lack of domestic funding and decreased funding for ART from the Global Fund. Procuring ART is beyond the scope of PEPFAR Angola's TA mandate. PEPFAR Angola will assist GRA with monthly ART pipeline analysis to inform procurement plans; provide TA to selected sub-national levels to improve warehouse management, consumption reporting, order fulfillment, pharmacy management; and ART dispensing.

Drawing on knowledge gained from the nine Luanda facilities, PEPFAR Angola will assist the GRA with updating and implementing an index case testing policy as part of the appropriate strategic testing mix. The lack of HRH makes facility- and community-level implementation of index case testing difficult, so PEPFAR Angola will train and mentor healthcare workers as part of its facility- and community-level TA to ensure index case testing is scaled up with fidelity in at least the four PEPFAR priority provinces.

4.4 Commodities

PEPFAR Angola will continue to assist the GRA in using updated tools for supply planning and will use its seat on the Angolan Quantification Working Group to advocate for the implementation of WHO guidelines and best practices. PEPFAR Angola will maintain assistance to the GRA for tracking consumption to develop realistic forecasting and inform supply plans to support the implementation of differentiated service delivery models, including MMS, TLD, and TPT.

The GRA has already stopped procuring NVP and decided to gradually transition patients from NVP-based regimens to TLE-400 as NVP becomes no longer available. PEPFAR Angola estimates the local NVP stock will last through September 2019. PEPFAR will continue supporting the GRA at national and sub-national levels for the effective transition away from NVP-based regimens.

As part of Global Fund's concept-note negotiations, the GRA has committed to procure 60% of ARV and RTKs needed until 2020 (see table 2.2.2); 40% is procured by UNDP as part of Global Fund program. PEPFAR will continue supporting the GRA and other stakeholders to use reliable and complete data for commodities security.

GRA publicly expressed their strong interest to introduce TLD in Angola as soon as June 2019. Since lead-time is approximately 6-9 months for ART to arrive in country and orders must be completed and submitted, PEPFAR Angola estimates the actual introduction of TLD among PLVIH currently receiving TLE will be mid FY2020.

4.5 Collaboration, Integration, and Monitoring

As previously described, the Global Fund program is prioritizing PMTCT optimization at the facility and community level. PEPFAR Angola is coordinating with Global Fund to ensure programmatic synergy where possible and avoid duplication of efforts. We are also collaborating with supply chain stakeholders, including World Bank and UNDP, the main Global Fund commodities implementer, to maximize available resources and advocate for the use of existing supply chain tools.

The President's Malaria Initiative (PMI) and USAID's Family Planning (FP) program support parts of DHIS2 development and implementation specific to their programs. Non-U.S.-government organizations are also looking at augmenting DHIS2 use. As PEPFAR Angola updates and expands the HIV-specific portion of DHIS2, staff will look for opportunities to repurpose trainings already created by other organizations and will ensure no duplication of efforts with our sister programs.

Additionally, the PMI program provides technical assistance to provincial and facility levels in Huambo and Lunda Sul. In Huambo, 20 PMI facilities provide Sexual and Reproductive Health/Family Planning (SRH/FP) and ANC services in health units where women receive HIV counseling and testing. If ART is not available, HIV-positive mothers are navigated to a nearby ART facility. Personnel training on DHIS-2 is occurring in 11 Huambo municipalities, in coordination with the MoH and provincial authorities. One DHIS2 support technician will mentor Huambo staff in 2019/2020 with PMI funding. Likewise, in Lunda Sul, an important collaboration opportunity is the coordination with the MoH on trainings, routine supervision, and IT maintenance, to ensure that recent and historical paper-based forms are inserted correctly into DHIS2. The Lunda Sul province routine supervision results convey relatively high reporting rates, 79%, in comparison to the national average at 25%.

In COP19, PEPFAR will engage in a mapping exercise with PMI to identify synergies to better determine the human resources distribution of PEPFAR staff for program oversight and supervision at the provincial and facility levels. PMI-Angola already maintains offices and staff in both Huambo and Lunda Sul.

PEPFAR Angola will use monthly supervision visits to IPs in the provinces and weekly coordination calls with IPs to ensure effective and efficient implementation of PEPFAR designed programming. New IPs are expected to be functioning at full capacity by the second quarter of FY2020. In cooperation with our IPs, PEPFAR Angola will conduct supervision visits with INLS technical staff from the different specialties (care and treatment, laboratory, supply chain and M&E) to all of the PEPFAR provinces every 4-6 weeks during COP19.

4.6 Targets for scale-up locations and populations

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	Tested for HIV (APR FY20) <i>HTS_TST</i>	Newly Identified Positive (APR FY20) <i>HTS_TST_POS</i>	Newly Initiated on ART (APR FY20) <i>TX_NEW</i>
Total Men	9,343	775	1,142
Total Women	229,975	11,318	12,125
Total Children (<15)	467	90	113
Total from Index Testing	21,794	6,213	
Adults			
TB Patients	964	191	97
Pregnant Women	208,311	5,461	5,188
Military	11,406	968	807
Other Testing	n/a	n/a	n/a
Previously diagnosed and/or in care	47,223		
Pediatrics (<15)			
HIV Exposed Infants	n/a	n/a	n/a
Other pediatric testing	467	90	113
Previously diagnosed and/or in care	949		

Table 4.6.2 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate (scale-up SNU's)	Coverage Goal (in FY20)	FY20 Target
Military Population	141,960	905	21,476
TOTAL	141,960	905	21,476

4.7 Viral Load and Early Infant Diagnosis Optimization

In Angola, the MoH mandates TB-HIV service optimization. The facilities with GeneXpert equipment use this platform for TB testing at below 20% of the platform's total capacity, so integrating HIV testing is simply a matter of optimization and capacity building. PEPFAR Angola will ensure efficient and impactful use of point-of-care (POC) instruments to support VL testing among pregnant and breastfeeding women through trainings, supportive supervision, and daily mentorship. PEPFAR Angola will support national and provincial levels to draft and implement policies and quality guidelines for HIV POC testing, operationalize a diagnostic network mapping, and support platform verification for DBS VL tests. An open dialogue between providers will be held at the national level to elaborate and resolve specific supply chain and connectivity issues. SOPs for VL data collection, reporting, and use will be written for lab and clinic systems as well as supply chain and data management. PEPFAR Angola will also strongly support regularly scheduled formative and supportive supervision visits to the facilities implementing DBS sample collection and POC testing to review recorded data for completeness, accuracy and quality.

In previous fiscal years, PEPFAR Angola procured GeneXpert machines for the MoH, mainly to strengthen TB diagnostics in PLHIV. These IV Module Xperts are in the National TB program's list for cartridge procurement. After equipment verification by INLS, the provincial and municipal health offices will procure cartridges for HIV testing and will ensure equipment maintenance.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The largest gap in the Angolan HIV care and treatment program is the limited availability, both in number and technical skills, of facility-level human resources. The MoH at all levels and INLS have acknowledged that gap multiple times and PEPFAR IPs regularly report the same gap. On a small scale, PEPFAR Angola's IPs are currently working day in and day out in their respective facilities and specialties to close that gap. Most of our Table 6 activities in COP19 are aimed at closing this HRH gap by increasing the technical skills of the existing MoH clinicians, laboratory technicians, supply chain managers, and other providers at all points of the cascade of care. PEPFAR Angola made a strategic shift away from national-level TA for writing policies to focusing on supervision, training, and mentoring at national, provincial, municipal, and facility levels for the implementation of policies and practices in COP19. PEPFAR Angola is also addressing a lack of highly educated professionals to fill middle to upper-management positions in the MoH through two masters-level training programs, one in supply chain management and the other in applied epidemiology. In the long term, both programs will produce well-trained Angolan professionals ready for absorption into MoH management positions. In the short term, the applied epidemiology program provides PEPFAR Angola with much needed additional capacity for implementation evaluations. Those evaluations will focus on multiple aspects of our family-focused PMTCT program, including risk factors for ANC defaulting, determinants for HIV testing in ANC facilities, barriers to HIV treatment at ANC facilities, determinants of ANC and delivery care, the impact of ANC HIV tracking tools, determinants of/barriers to testing index cases of pregnant women, and the impact of DHIS2 training on data quality and completeness.

Data that are easily accessible for decision making is another major gap in Angola's HIV cascade of care. That gap was especially evident during our data analysis for aligning PEPFAR investment to geographic disease burden. We learned that the MoH MCH branch does not use DHIS2 to report ANC visits or any other data we wanted for our analysis. We realized that the current setup of DHIS2 makes data extraction from the system very cumbersome and nearly impossible for use in real-time decision making. We also saw that outside of Luanda, use of DHIS2 is often limited to data reporting only at the provincial level. DHIS2 has parallel reporting paths for HIV data due to an incomplete roll out of updated M&E tools from the national level which further complicates data extraction and analysis for program decision making. We also experience gaps in data for making program decisions every quarter when we need clean, accurate data for MER indicator reporting. Some of the necessary data is not available through the routine INLS data collection mechanism, given the PEPFAR-specific data points. Supplemental data is available, but oftentimes requires extensive cross-checking to ensure accuracy. This labor-intensive cross-checking is neither feasible nor sustainable at the non-PEPFAR supported MoH facilities. The MoH, INLS, and PEPFAR Angola see prohibitive difficulties accessing the information necessary to make program decisions in a timely and effective manner.

These findings shaped multiple interventions in COP19. One will be a DHIS2 update and upgrade for HIV reporting with trainings for the new system at all levels of implementation. As we train and mentor MoH staff for HIV data entry, we will also train and mentor MoH staff for ANC reporting into DHIS2. The other intervention, at INLS's request, will be support for INLS to implement their updated HIV M&E reporting tools in all provinces and to ensure the tools are being properly used especially in the PEPFAR priority municipalities. Full implementation of the updated M&E tools will require archival of data based on the old tools for which PEPFAR will provide TA. PEPFAR Angola will also provide financial support for M&E supportive supervision visits from national to provincial levels, and mentoring/training for data collection and data use at all levels.

INLS realizes there is a gap in patient-level data for decision making and patient management, especially outside of Luanda where there is minimal access to VL testing. That gap in necessary patient data is due to the lack of a national specimen transport system, and limitations in the national and sub-national laboratory guidelines, operational plans, job aids, and laboratory-specific M&E tools. PEPFAR Angola will assist INLS in closing the patient-level data gap using enhanced facility-level training and mentorship; providing certification opportunities at laboratory and individual levels (for management, quality assurance, and technical staff); and supporting central and provincial level trainings on laboratory quality assurance, dried blood spot (DBS) use for VL testing, integration of TB/HIV diagnostic point of care solutions, and specimen transport. In order to maximize the existing laboratory capacity, PEPFAR Angola will provide TA to improve the Viral Load Sample Management (VLSM) and Information System at the central laboratory and at provincial levels. We will support implementation of several VL laboratory M&E tools and job aids that will facilitate reporting VL results to the clinicians responsible for treatment decisions for each patient tested. As we further explore health information systems with INLS and MoH, we will continue our discussion about the possibility of implementing unique identifiers as another method to close the patient level data gap.

To address the commodities procurement gaps, the Angolan MoH requires additional funding. PEPFAR Angola's TA will supply the MoH with the necessary forecasting and planning data to strengthen the MoH's domestic and international advocacy for ARVs and other HIV commodities, as well as necessary drugs for TB treatment and prophylaxis funding. Better informed advocacy could lead to more funding, which will enable the necessary transition to TLD as the first-line ART regimen and complete the elimination of NVP-based regimens. PEPFAR Angola will provide TA at national and provincial levels to strengthen warehouse management, distribution, and pharmacy management to enable MMS in selected provinces as soon as the MoH secures funding for the commodities. These PEPFAR investments, in collaboration with the Global Fund ART procurement and a new World Bank project designed to improve supply chain security in Angola's health sector, will produce sustainable improvements in the GRA supply chain system. PEPFAR Angola's ultimate supply chain goal for COP19 is to assist the GRA's transition to a TLD-based ART regimen while ensuring stock levels can support MMS.

INLS lacks a framework and policies for community-based HIV interventions. That policy gap limits INLS's ability to maximize on any impact toward epidemic control that could be provided by interventions at the community level. PEPFAR Angola will use TA to implement evidence-based testing and retention interventions at the community level. The team will also provide national-level TA policy development around the Mentoring Mothers Model and other evidence-based community interventions, including the implementation of a cadre of trainers to expand

useful programs nationally. PEPFAR Angola’s community activity complements GRA and Global Fund efforts in selected provinces and ensures the success of the First Lady’s Initiative to achieve elimination of MTCT (eMTCT).

Because a family-focused PMTCT program has not been implemented in Angola before and PEPFAR Angola has not worked outside of Luanda in many years, the team anticipates identifying more gaps and refining existing areas for TA before COP19 implementation. PEPFAR Angola is planning to do site visits in the four provinces. During those visits, Data Quality Assessment (DQAs) will be conducted, first at the primary focus TA facilities, and if time and funding permit, at the secondary focus TA facilities, to get a better understanding of the baseline and to further plan data collection and M&E TA for each facility. The team will meet with the provincial health directors, HIV focal points, and MCH focal points in Cunene and Lunda Sul to better understand their province-specific barriers to implementing PMTCT and HIV care; PEPFAR staff already met with individuals from Benguela and Huambo in March 2019. The team hopes to travel with representatives from INLS for site visits and provincial level meetings to better understand the national perspective of what is encountered in the provinces. PEPFAR Angola will also continue conversations with INLS about how to best fill the gaps identified together.

PEPFAR Angola will use SMART (Specific, Measurable, Achievable, Realistic, and Time-bound) benchmarks, including MER indicators wherever appropriate, to monitor and track the implementation of all PEPFAR investments in Angola. The team will measure its success by increased policy implementation evidenced by increased testing, treatment, and ultimately viral load suppression especially in priority provinces, and increased use of data by INLS for program decision making and by clinicians for patient care decision making.

All of the above-mentioned system level investments build on existing infrastructure and will ultimately ensure that Angola is able to move itself toward epidemic control.

See Appendix C for additional details.

6.0 Staffing Plan

The 40% budget cut between COP18 and COP19 forced PEPFAR Angola to become more efficient in implementing its programming, as evidenced by a more streamlined and integrated approach to TA. This decreased budget also forced the team to look closely at the cost of doing business (CODB) and decrease that cost as much as feasible. Staffing is the costliest component of doing business, and OGAC mandated a significant cut in that cost by requiring PEPFAR Angola to reduce our off-shore hired staff to one person, the CDC Country Director. Proposed CODB for COP19 represents a significant reduction on USAID’s CODB, at 35% and 48% reductions in comparison to COP18 and COP17 levels, respectively. The USAID Senior HIV Technical Advisor position will be eliminated by the end of December 2019 when the current contract ends. USAID is proposing a new locally employed staff (LES) position (HIV Technical Advisor) to replace existing Senior HIV Technical Advisor.

To ensure effective TA to INLS and sufficient capacity for IP management, USAID will create an additional HIV Specialist position that will be filled by a LES. PEPFAR Angola will retain the 6.5 currently employed LES, four funded by CDC, one and a half funded by USAID, and one funded by DOD. Our PEPFAR Coordinator position will also be funded for COP19. PEPFAR Angola will continue to increase interagency cooperation more than ever before during COP19 and beyond.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

Angola		SNU Prioritizations					Total *
		Attained	Scale-Up: Saturation	Scale-Up: Aggressive	Sustained	Centrally Supported	
HTS_INDEX	<15					289	306
	15+					20,425	21,488
	Total	-	-	-	-	20,714	21,794
HTS_TST	<15					289	516
	15+					226,087	237,385
	Total	-	-	-	-	226,376	237,901
HTS_TST_POS	<15					87	102
	15+					11,587	12,272
	Total	-	-	-	-	11,674	12,374
TX_NEW	<15					105	113
	15+					7,278	8,079
	Total	-	-	-	-	7,383	8,192
TX_CURR	<15					1,205	1,205
	15+					32,576	43,367
	Total	-	-	-	-	33,781	44,572
TX_PVLS	<15					313	394
	15+					8,125	10,743
	Total	-	-	-	-	8,438	11,137
CXCA_SCRN	Total (15+)					-	-
OVC_SERV	<18					-	-
	18+					-	-
	Total	-	-	-	-	-	-
OVC_HIVSTAT	Total (<18)					-	-
PMTCT_STAT	<15					-	-
	15+					208,311	208,311
	Total	-	-	-	-	208,311	208,311
PMTCT_STAT_POS	<15					-	-
	15+					8,110	8,110
	Total	-	-	-	-	8,110	8,110
PMTCT_ART	<15					-	-
	15+					7,705	7,705
	Total	-	-	-	-	7,705	7,705
PMTCT_EID	Total					-	-
PP_PREV	<15					-	215
	15+					-	21,262
	Total	-	-	-	-	-	21,477
KP_PREV	Total					-	-
KP_MAT	Total					-	-
VMMC_CIRC	<15					-	-
	15+					-	-
	Total	-	-	-	-	-	-
HTS_SELF	Total					-	-
PrEP_NEW	Total					-	-
PrEP_CURR	Total					-	-
TB_STAT (N)	<15					-	61
	15+					-	895
	Total	-	-	-	-	-	956
TB_ART (N)	<15					-	68
	15+					-	317
	Total	-	-	-	-	-	385
TB_PREV (N)	<15					1,082	1,101
	15+					29,478	29,739
	Total	-	-	-	-	30,560	30,840
TX_TB (N)	<15					1,271	1,489
	15+					34,678	41,768
	Total	-	-	-	-	35,949	43,257
GEND_GBV	Total					-	-

* Totals may be greater than the sum of categories due to activities outside of the SNU prioritization areas outlined above

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (APR FY19)	Additional patients required for 80% ART coverage	Target current on ART (APR FY20) TX_CURR	Newly initiated (APR FY20) TX_NEW	ART Coverage (APR 20)
Attained	n/a	n/a	n/a	n/a	n/a	n/a
Scale-Up Saturation	n/a	n/a	n/a	n/a	n/a	n/a
Scale-Up Aggressive	n/a	n/a	n/a	n/a	n/a	n/a
Sustained	n/a	n/a	n/a	n/a	n/a	n/a
Central Support	86,523*	83,656*	--	44,572	8,192	29%
Total	86,523	83,656	--	44,572	8,192	29%

* Spectrum estimate, 2019

APPENDIX B – Budget Profile and Resource Projections

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

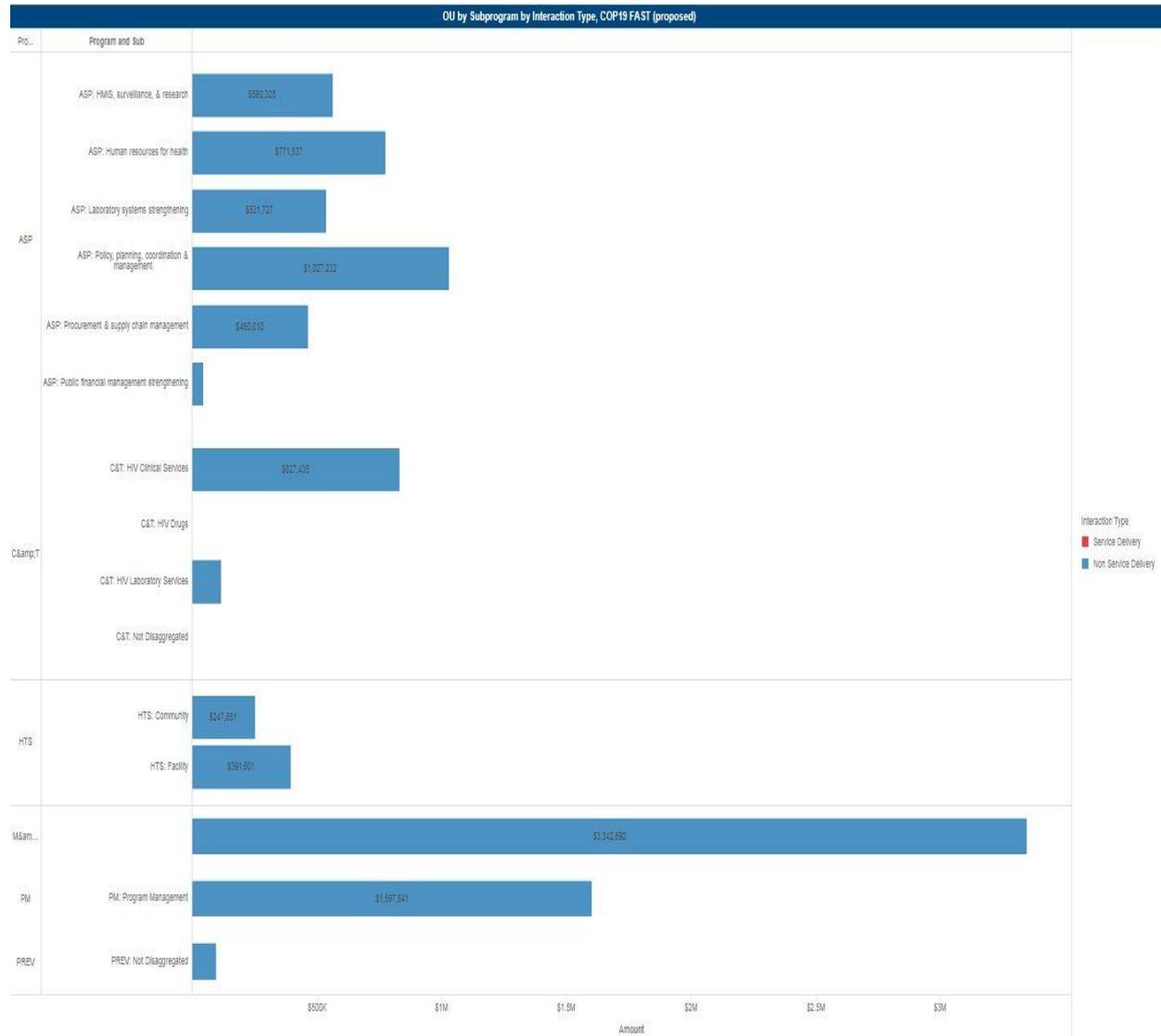


Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	New Funding	Total Spend
\$4,666,332	\$5,333,668	\$10,000,000

Table B.1.3 Resource Allocation by PEPFAR Budget Code

Initiative Type	Fiscal Year	2020
	Budget Code	Amount
Planning Level	APPLIED PIPELINE	\$4,666,333
	HBHC	\$79,279
	HLAB	\$168,429
	HTXS	\$571,050
	HVCT	\$295,820
	HVMS	\$883,749
	HVSI	\$366,828
	HVTB	\$195,378
	MTCT	\$582,909
	OHSS	\$2,190,225

APPENDIX C– Minimum Program Requirements

Key Policy advancements including COP19 minimum program requirements	Status of policy change
1. Adoption and implementation of Test and Start for all	The GRA and PEPFAR-Angola have agreed to transfer lessons learned from PEPFAR-supported sites in Luanda to the provincial level in COP19 to address national-level implementation barriers to Test and Start. This support will come in the form of reformatted tools and SOPs for improving same-day ART initiation and tracking patient enrollment.
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS)	The GRA has a policy for MMS in place, but challenges remain in implementing this policy nationally. PEPFAR-Angola will support supply chain security and will transfer lessons learned from PEPFAR-supported sites in Luanda.
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens	The GRA currently has a plan for elimination of NVP and two draft policies for the roll out of TLD, one that includes use among women of reproductive potential and one that does not. The GRA has been getting significant input by its local WHO representative to wait for the release of study results, making negotiations with the GRA to initiate transition to TLD extremely difficult. However, PEPFAR-Angola reported that the Minister of Health is now promising to roll out appropriate TLD guidance by October of 2019. Support for TLD rollout from PEPFAR will include registration, forecasting, and deployment of TLD as first line. PEPFAR-Angola efforts to support PMTCT through ANCs will include the use of TLD for HIV-positive women and their children/partners identified as positive through this effort.
4. Scale up of index testing and self-testing	The GRA has a national-level policy for index testing and is still considering policies for self-testing. PEPFAR-Angola will transfer lessons learned (inclusive of tools and SOPs) from the PEPFAR-supported facilities in Luanda to support execution of these interventions nationally. PEPFAR-Angola will continue to encourage the expansion of self-testing beyond the currently funded key population work.

5. Scale up of TB preventive treatment (TPT) for all PLHIV as an integral and routine part of the HIV clinical care package (No longer required per PLL)	Current GRA plan is to procure commodities for ~20,000 PLHIV. PEPFAR Angola TA will include TPT supplies as part of its TA in forecasting, planning and distribution of commodities. PMTCT and family care TA at the provincial, municipal and facility level will include promotion of the implementation of TB diagnosis and TPT provision as a critical element of comprehensive ART care.
6. Direct and immediate (>95%) linkage of clients from testing	Met per final submitted Data Pack targets
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services	Not required per PLL
8. Completion of VL/EID optimization across all age groups	Not required per PLL
9. Monitoring and reporting of morbidity and mortality outcomes	Not required per PLL
10. Alignment of OVC services and integrated case management	N/A; no OVC services provided by PEPFAR in Angola
11. Evidence of resource commitments by government with year-after-year increases	Not required per PLL; GRA has committed to double overall health spending from ~3.7% to 7.1% of the federal budget from FY19 to FY20 Both PEPFAR and Global Fund encouraging the GRA to procure enough commodities to meet their co-financing requirements
12. Agency progress toward indigenous prime-partner funding	CDC increasing funding to the MOH; limited local capacity for other partners
13. Scale up of unique identifiers	The GRA has a weak medical data infrastructure, with few facilities with the capability to maintain EMRs or link to DHIS. PEPFAR-Angola will focus on improving necessary infrastructure upon which to add unique identifiers in the future. PEPFAR-Angola will continue discussions with the GRA through COP 2019 as they plan for COP 2020.

APPENDIX D – Tables and Systems Investments for Section 5.0

Table 6-E									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Baseline Data
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 79,292	Forecasting, supply chain plan, budget, and implementation	Antiquated ART regimen	COP19	COP21	2018 budget for TLD = \$0 2018 budget for NVP= \$1,231,037
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 29,902	Forecasting, supply chain plan, budget, and implementation	Inadequate access to medication for patients	COP18	COP21	MOH procured \$4,183,364 of \$8,672,259 planned (50% under-supplied)
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 216,122	Forecasting, supply chain plan, budget, and implementation	Incomplete coverage of HIV testing and treatment services in health facilities	COP19	COP21	No available information, since PEPFAR will start working outside Luanda in COP19 implementation
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 34,321	Forecasting, supply chain plan, budget, and implementation	Incomplete coverage of HIV testing and treatment services in health facilities	COP19	COP21	4 months (January 2019)
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 75,369	Product selection, registration, and quality monitoring	Inadequate access to medication for patients	COP19	COP21	DTG not registered in country yet. CECOMA is not the main warehouse for ARV.
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 25,004	Training in supply chain systems	Inadequate access to medication for patients	COP18	COP21	35 (COP18 benchmark)
USAID	TBD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 216,661	Oversight, technical assistance, and supervision to subnational levels	Incomplete coverage of HIV testing and treatment services in health facilities	COP19	COP21	1) MMM not under implementation in Angola 2) No training curriculum for training of trainers 3) 0 provinces implementing MMM
USAID	TBD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 216,661	Oversight, technical assistance, and supervision to subnational levels	Incomplete coverage of HIV testing and treatment services in health facilities	COP19	COP21	1) ICCT tools not updated 2) No ICCT under implementation 3) Curriculum for training of trainers not updated
USAID	TBD	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 85,866	Program and data quality management	Inadequate facility-level supervision by national and provincial levels	COP19	COP21	1) No community M&E tools 2) No Community M&E under implementation
HHS/CDC	TBD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 233,874	National strategic plans, operational plans and budgets	Inadequate facility-level supervision by national and provincial levels	COP19	COP21	DQAs not happening
HHS/CDC	TBD	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 307,039	Oversight, technical assistance, and supervision to subnational levels	Inadequate facility-level supervision by national and provincial levels	COP18	COP20	Tools being used in 3 provinces but not in all facilities in those provinces
HHS/CDC	TBD	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 108,000	Training in HMIS systems or processes	Lack of a national health information system to monitor patients and evaluate programs	COP19	COP20	34/166= 20% nationwide able to report
HHS/CDC	TBD	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 200,000	HMIS systems	Lack of a national health information system to monitor patients and evaluate programs	COP19	COP19	30% of DHIS2 indicators correspond to paper-based tools; 60% of needed indicators exist in DHIS2

Table 6-E									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Baseline Data
HHS/CDC	TBD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 108,000	National strategic plans, operational plans and budgets	Antiquated ART regimen	COP18	COP19	Updated guidelines expected to be finalized by July 2019 after results of TLD study in Botswana are released
HHS/CDC	TBD	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 368,131	Institutionalization of in-service training	Insufficient number of trained healthcare workers to implement HIV cascade of care	COP18	COP19	0%
HHS/CDC	NATIONAL INSTITUTE OF AIDS	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 116,000	Oversight, technical assistance, and supervision to subnational levels	Lack of government pressure or incentives to implement existing policies	COP18	COP19	1.) Annual provincial level supervision visits WITHOUT any documentation or follow-up work plan; 2.) 25% timely data submission
HHS/CDC	NATIONAL INSTITUTE OF AIDS	ASP: Public financial management strengthening	Non-Targeted Pop: Not disaggregated	\$ 40,000	Administrative and financial systems	Lack of government pressure or incentives to implement existing policies	COP19	COP20	1.) 0%; 2.) 0
HHS/CDC	NATIONAL INSTITUTE OF AIDS	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 60,000	Oversight, technical assistance, and supervision to subnational levels	Lack of government pressure or incentives to implement existing policies	COP19	COP19	annual
HHS/CDC	AFRICAN FIELD EPIDEMIOLOGY NETWORK	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 6,000	Clinical guidelines, policies for service delivery	Incomplete coverage of HIV testing and treatment services in health facilities	COP19	COP19	No lab HIV testing guidelines
HHS/CDC	AFRICAN FIELD EPIDEMIOLOGY NETWORK	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	\$ 250,400	Training in laboratory systems strengthening	Poor access to laboratory testing	COP19	COP21	No VL testing outside of Luanda province
HHS/CDC	AFRICAN FIELD EPIDEMIOLOGY NETWORK	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	\$ 150,000	Training in laboratory systems strengthening	Poor access to laboratory testing	COP19	COP19	1.) 0; 2.) 30%; 0
HHS/CDC	NATIONAL SCHOOL OF PUBLIC HEALTH, GOVERNMENT OF REPUBLIC OF ANGOLA	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 96,667	Pre-service training	Insufficient number of trained healthcare workers to implement HIV cascade of care	COP16	COP20	No recent PMTCT implementation evaluations
DOD	CHARLES DREW UNIVERSITY OF MEDICINE AND SCIENCE	ASP: Laboratory systems strengthening	Priority Pops: Military & other uniformed services	\$ 131,327	Training in laboratory systems strengthening	8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups	COP19	COP19	1) 55%; 2) 2 military reference labs; 3) 33%; 4) 21
DOD	CHARLES DREW UNIVERSITY OF MEDICINE AND SCIENCE	ASP: HMIS, surveillance, & research	Priority Pops: Military & other uniformed services	\$ 166,462	Program and data quality management	13. Scale up of unique identifier for patients across all sites.	COP19	COP20	1) 70%; 2) 65%; 3) 70%.

Table 6-E									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Baseline Data
DOD	CHARLES DREW UNIVERSITY OF MEDICINE AND SCIENCE	ASP: Policy, planning, coordination & management	Priority Pops: Military & other uniformed services	\$ 70,036	Training in coordination and management of health systems	2. Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents.	COP19	COP20	1) 80%; 2) 80%.