Health for All (HFA)

Population Services International (PSI)

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Country Representative: Anya Fedorova, email: anya.fedorova@psiangola.org

Chief of Party: Paulo R Proto de Souza, email: pproto@psiangola.org

HEALTH FOR ALL – YEAR 1 – QUARTER 4 (JUL-AUG-SEP 2017)

In January 2017, Population Services International-led Consortium was awarded RFA-654-16- 000004 to implement project Health for All (HFA), from FY17-FY21. HFA includes three health areas: Malaria, HIV/AIDS and Family Planning. Each of the health areas achieved important results in FY17, despite having only 8 months since HFA's inception (Feb 2017).

The following report describes main achievements per Objective/Expected Result that happened between July 1st and September 30th, 2017 (4th Quarter of Year 1). This report also serves as an Annual Report, since the final results of Year 1 are also demonstrated.

Result 1: LLIN Access and Use Increased by at least 30%.

According to WHO's Position Statement on Insecticide Treated Nets/ITNs (2007), ITNs have been shown to reduce all-cause child mortality by about 20%, decrease clinical cases of malaria by about 50%, and severe malaria by 45%. During Y1, HFA has covered 5 provinces of Angola, as a phase 1 of the universal coverage campaign.

1.1 Targets for FY1:

During the first phase of the LLIN Distribution, 5 provinces were covered: Kwanza Sul, Kwanza Norte, Malanje, Zaire and six municipalities of Uige.

The following targets were set for phase 1 of the Distribution Campaign:

- 2,900,000 LLINs to be distributed
- 4,156,920 beneficiaries to be covered in the 5 provinces (estimated by DPS)
- 4,000 activists to be recruited and trained on malaria counselling and campaign tools to conduct community activities

1.2 Main achievements of LLIN distribution in FY1:

Performance Indicators	Baseline 2015-16	Target 2017	Achieved			Achieved /Target
			Q3	Q4	Total	
1. Number of insecticide treated nets (ITNs) that were distributed in this reported fiscal year.	1,739,431	2,900,000	1,276,196	1,117,281	2,393,477	**84.2%**
2. Number of community HWs trained in counseling on ITN use in this reported fiscal year.	399	4,000	2,503	2,261	4,764	**119.1%**
3. Number of households with at least one ITN for every two people in this reported fiscal year.	106,864	1,000,632	524,502	395,691	920,193	**92.0%**
4. Number of Children covered with ITN in this reported fiscal year.	**187,944**	**892,086**	**341,227**	**330,954**	**672,181**	**75.3%**

Further details on achieved results:

- **2,393,477 treated mosquito nets (ITN) were distributed**, corresponding to **86.18%** of the prepositioned LLINs in the 5 provinces.
- **2,777,400 LLINs** were pre-positioned in the 5 provinces by PSM, what corresponds to **95.77%** of the expected 2.9 million.
- **383,923 LLINs** remained in the 5 provinces, some of which to be used for routine distribution.

- **4,258,952 beneficiaries registered** with access to mosquito nets:
  - **920,193** households
  - **105,672** pregnant women
  - **672,181** children under 5 years of age
- **2.5% more people** than estimated (based on projections of the 2015 Census) were registered during the campaign. This reflects positively on the increase of LLIN access and use, according to a survey conducted by Vectorworks in sub-Saharan Africa, which concluded that among those who own a net, use is very high (89%) in Angola.
- **4,764 community activists** were trained in the required skills for communication, registration and distribution of LLINs in the field, 19% more than the expected. That was in response to the challenges posed by the long distance and extension of the communities, as well as the number of population which was different from the initial estimates.
- **90 community members were trained as trainers (ToT)** for capacity development of *activistas*. The number of trainers was estimated according to the number of activists. Each trainer trained between 25-30 activists.

1.3 Major Constraints faced during FY1:

- **Insufficient time to prepare for the Distribution Campaign before its inception** – the 1st phase of the campaign was accelerated due to pending national elections on August 23rd. With prior consent from NMCP and the Campaign Management Committee, communication materials and other tools from previous campaigns were adopted and any updates postponed to a later stage.
- **Low availability of resources in the provinces –** distribution of LLINs in each province was split in two groups of municipalities: those closer to the provincial capital were done first, followed by more distant municipalities, what allowed for optimal use of resources, specially transportation.
- **Hard to reach communities –** activists were recruited locally. Registration and distribution activities were combined and implemented simultaneously.
- **Absence of people at home during the household registration and distribution** – with the support of the community leaders ("sobas"), registration time was extended to give a second chance to people who missed the registration in the community. In consultation with DPS and DMS, 4 bales (about 200 mosquito nets) were left behind with each DMS after the campaign ended to address possible complaints from people who were unable to be present during distribution.
- **Activists with difficulty in managing campaign tools –** the trainers reinforced the field team with supportive supervision and monitoring to ensure proper use of registration and distribution tools.
- **Malaria emergency in Huambo –** the upsurge of malaria cases in Huambo was declared an emergency by DNSP, and PSI was requested to support the province with distribution of bednets, planned for August 2017. With that in mind, PSI field team and other resources were mobilized to the province, awaiting prepositioning of LLINs and a final decision on the date to start distribution. Eventually, the distribution was called off by DNSP, and the PSI field team returned to Luanda. That caused some unnecessary costs and delays in the preparations for phase 2 of the distribution, planned for Oct-Nov/17.

1.4 Recommendations for FY2:

- Final decision on provinces to be covered in phases 2 and 3 should happen in a more timely manner to avoid delays in planning and cause increased expenses in distribution.
- No activity should be initiated without the official decision from the NMCP/DNSP clearly communicated to the provincial authorities.
- In the field, registration and distribution activities should be combined in areas of difficult access to facilitate logistical operations and optimization of time.

- The number of activists and their activities in the field must be optimized to facilitate their administrative management. PSI proposes to reduce the number of activists by combining pre -communication and registration tasks under one activist. That will allow to reduce the activists' costs significantly.
- PSI should work more closely with NMCP to define a clear communication strategy for the distribution campaign, in coordination with other partners (e.g. ADECOS, UNITEL).
- Planning time in the provinces should be optimized with microplanning in the municipalities without doing provincial macroplanning, since they are redundant.
- Activists should have a job aid (manual) to guide their activities when they are in the field.
- The training program should to be revised to include more practical exercises in the field.
- To streamline training activities, training should be provided to other trainers directly in the provinces.

1.5 Proposed targets for FY2:

LLIN Distribution in the remaining 9 (nine) provinces will be divided in 2 phases:

- **Phase 2:** Oct-Nov 2017: Namibe and Cunene
- **Phase 3:** Mai-Jul 2018 (after the rainy season): Cabinda, Bie, Bengo, Lunda Norte, Lunda Sul, Moxico and Cuando Cubango. Huambo might be included later.

Targets:

- Distribution of 5.6 million LLINs (provided the distribution funds and availability of nets are confirmed)
- Population to be covered: 9.5 million (236,000 pregnant women + 1.4 million children >5)
- 5,400 "activistas" to be trained in communication, registration and distribution
- Distribution Management Plan (kit): to be developed during the first 2 quarters of FY02 and delivered to NMCP to assist in future distribution campaign.
- Social Behavior Change Communication campaign: pre- and post-campaign plan to be updated and implemented in coordination with NMCP and other communication partners (ADECOS, UNITEL).

1.6 Environmental Mitigation Monitoring Plan (FY01):

Health for All – Quarter 4 Report (FY17)
EMMP

Result 1: LLIN			
Indicator	Achieved		
	Q3	Q4	Total
1. Number of households receiving messages on appropriate use of LLIN	915,637	4,556	**920,193**
2. Number of activists trained on communicating correct LLIN use messages to the population	2,503	2,261	**4,764**

Result 2: Malaria Services throughout Targeted Municipalities Improved

2.1 Targets for FY1:

In FY01, the key performance targets were renegotiated with USAID and changed (table below) due to the abbreviated implementation timeline of HFA (Feb-Sep 2017) and the legislative elections in August that limited field activities with government personnel.

Indicator Type: *Standard Indicators*	**PSI Proposed FY17 Targets**	**PMI FY17 Targets**
3.1.3.1-1 Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds	**1,000**	**2,000**
3.1.3.1-5 Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTs) or microscopy) with USG funds	**350**	**700**
3.1.3.4-1 Number of health workers trained in intermittent preventive treatment in pregnancy (IPTp) with USG funds	**300**	**600**

2.2 Main achievements in Quarter 4 and Year 1:

During FY2017 (Year 1), a total of 67 trainings of health workers, namely Doctors and Nurses, took place on management of cases of uncomplicated malaria and control of malaria in pregnancy (MiP) in 24 target municipalities of 6 provinces (Cuanza Norte, Malanje, Lunda Sul, Lunda Norte, Uige, and Zaire).

These health professionals were also trained on rapid diagnose of malaria using RDT. The trainings aimed to contribute to the reduction of morbidity and mortality in the general population by improving the competence of health workers in malaria case management and adequate implementation of intermittent preventive treatment in pregnant women (IPTp).

The specific objectives of the trainings were: (i) to provide participants with knowledge, skills and practices for the diagnosis with quality and correct treatment of patients with suspected of uncomplicated malaria; (ii) to train doctors and nurses in the diagnosis of malaria using RDT; (iii) to train nurses/midwives of ANC with technical knowledge, skills and practices on malaria control during pregnancy; (iv) advise health workers on quality referral of patients with suspected severe malaria; (v) contribute to the improvement of knowledge related to the differential diagnosis of febrile syndromes and (vi) raise awareness of trainees towards IEC/BCC actions on malaria prevention.

In total**, 1,083** health providers were trained on malaria case management with the use of ACTs, **374** nurses or midwifes trained on malaria in pregnancy (MiP), and **1,024** health workers were trained on malaria rapid diagnostic test (RDTs) during FY1.

IR2: Malaria case management (6 provinces, 24 municipalities)						
Performance Indicators	**Baseline 2016**	**Target 2017**	**Achieved**			**Achieved /Target**
			Q3	**Q4**	**Total**	
1.Number of health workers trained in intermittent preventive treatment in pregnancy (IPTp) with USG Funds in the fiscal year.	1,689	300	20	354	**374**	**124%**
2. Number of health workers trained in malaria diagnostics (RDTs or microscopy) with USG funds in the fiscal year.	1,247	350	75*	949*	**1024**	**341%**
3. Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds in the fiscal year.	2,868	1000	75	1008	**1083**	**108%**

4. Number of health workers who received formative supervision on malaria diagnostic in the fiscal year.	-	124	FY2	FY2	FY2	**0%**
5. Number of health workers who received formative supervision in ACT use in the fiscal year.	-	124	FY2	FY2	FY2	**0%**

2.3 Reasons for over/under achievements:

- **Why over training in MiP/ACTs (108%)?** Some DPS requested additional participation of HW from municipalities that lacked trained staff in MiP, thus increasing the number of participants;
- **Why over training in rapid testing (341%)?** The national guidelines/policy followed by the NMCP determines that all HW being trained in ACT management must also be trained in the use of rapid test (RDT), since they are the ones using the RDTs. So, all HW were trained in use of RDTs;
- **Why no supervision?** Since all provincial trainings of prescribers and ANC nurses took place during the month of September 2017, there was no time to initiate supervision of ACT prescribers. That will take place during Y2. As for supervision of the 124 HW trained by World Learning in 2016, they will also be supervised during FY2. The focus in FY1 was on preparing and implementing the new ToT and implementing the provincial training of ACT prescribers and MiP.

2.4 Major Constraints faced during FY1:

- The number of provincial certified trainers listed on the formal letter from DNSP was not enough to carry out a very high number of trainings within three weeks: through coordination meetings with NMCP and DPS, the number of trainers was increased (by using national ToTs).
- The hired vehicles were not enough to transport trainees and facilitators during the coffee break and lunch time: the costs of fuel for DPS vehicles were covered by PSI.
- Facilitators were very unhappy about the lack of facilitation subsidies that were not allowed under USAID regulations: PSI paid per diems to all trainers who gave trainings outside their home municipalities.
- Training overload and delays on starting sessions, especially on the first day of training, due to organizational burden of more than one training happening at the same time: PSI sent one experienced provincial coordinator to each province to support the OPMs and facilitators.
- Constant power cuts during training sessions: PSI covered costs of fuel to supply Hospitals/ DPS electric generators.
- Transport of trainees from their home municipalities to municipalities hosting the trainings: transport subsidy (for local trainees) or per diem for outside participants were provided by PSI.
- Poor catering services in terms of quantity and quality, as the providers had to serve 2 or 3 classes per day: PSI immediately contacted the catering providers to correct problems, identifying alternative service providers where needed.

2.5 Recommendations for FY2018:

Based on the lessons learned from the trainings implemented during FY1, we recommend that:

- The DNSP and NMCP should officially inform the DPS, the DMS and respective Municipal Administrations of each target province before implementing any activity in the future, to avoid misunderstandings and misinformation that could disrupt the activities;
- HFA technical team should allocate more days and time for the training to enable trainees to better assimilate the topics under discussion;

- USAID should review the policy of the payment of per diems within the provinces;
- Activity implementers in the provinces should have a portable field generator and predict funds for fuel purchase;
- Implementers should conduct trainings at municipal headquarters to reduce transportation costs of trainees;
- More trainings should be provided to malaria prescribers and nurses/midwifes working in ANC clinics at provincial level (low level of competence identified);
- Formative supervision activities should start at the onset of Q1/FY02 in all priority municipalities of the 6 PMI provinces;
- Immediately after trainings take place in the provinces and municipalities, NMCP and HFA should start providing monitoring and supervision to trained staff to guarantee quality of services. For this purpose, supervisors from central level (DNSP/DNSSR/NMCP) are to be deployed to join the supervision provincial team in carrying out monitoring and supervision of trained staff;
- Training of lab technicians on malaria diagnosis through microscopy should start in Q1/ FY2, followed by monitoring and supervision;
- Reinforce social mobilization activities at community level to increase motivation and promote active participation of target populations, especially young women, on malaria prevention and appropriate treatment.
- HFA should continue attending meetings of ADECOS/iCCM Technical Working Group so as to foster the improvement of the strategy and expand iCCM to other provinces in Angola.

2.6 Proposed targets for Y2:

Note: *The previous year target established for HFA (2,000 HW trained/year) is not achievable, because there aren´t enough health workers in the existing 407 Health Units in the PMI provinces and target municipalities.*

HFA Result 2 – Targets for FY02			
Province	**# of existing health facilities (HF)**	**# of personnel targeted for training (3/HF)**	**# of lab technicians targeted for training (1/HF)**
Malanje	84	252	84
Lunda Norte	39	117	39
Lunda Sul	49	147	49
Cuanza Norte	57	171	57
Zaire	53	159	53
Uige	125	375	125
TOTAL	**407**	**1,221**	**407**

2.7 Environmental Mitigation Monitoring Plan:

Health for All – Quarter 4 Report (FY17)
EMMP

Results 2: Malaria case management (6 provinces, 24 municipalities)			
Indicator	Achieved		
	Q3	Q4	Total
1. Number of facilities in compliance with waste management standards	NA	NA	NA
2. Number of ToTs trained on lab waste management	0	11	11
3. Number of health workers trained in waste management	75	1008	1083
4. Number of ADECOS trained in waste management	0	0	0

Result 3: Sustainable model for providing high-quality HIV/AIDS services established

3.1 Background:

In FY17, HFA/MSH ensured the high-quality implementation of HIV testing activities and the linking of newly diagnosed HIV positive individuals to care and treatment services inside the nine designated PEPFAR facilities in Luanda. These activities complemented those of ICAP, CDC's technical assistance (TA) implementing partner, who was responsible for care and treatment activities.

Between June and September 2017, HFA/MSH focused on providing Technical Assistance (TA) to seven supported sites instead of nine on HIV testing and care and treatment activities. In addition, HFA/MSH began shadowing ICAP on TB/HIV co-infection services and Viral Load monitoring, and conducted three operational assessments of the project's seven health facilities to identify gaps and inform TA efforts moving forward.

3.2 Summary of Major Achievements

During FY1 (2017), MSH is leading all HIV-related facility-based activities of IR3-HFA that focus on HIV Counseling and Testing and linkage to Care and Treatment, including technical assistance and supporting training materials and improvements in the quality of continuum of care (COC) model, so that it can be sustainable and scalable. The following table shows HFA/ MSH achievements by indicator across the nine health units (HU) in which HFA works:

Health for All – Quarter 4 Report (FY17)

IR3: Activities in 9 health units (Luanda)

Performance Indicators	Baseline 2015-16	Target 2017	Achieved				Achieved / Target
			Q2	Q3	Q4	Total	
1 HTC_TST HIV Testing Services	*62,186	49,372	25,699	29,922	14,295	75581	153%
2 TX_NEW New patients in treatment	3,390	5,816	1,420	1,572	705	3,697	64%
3 TX_CURR Current patient in treatment	19,189	25,417	21,990	23,067	?	45057	177%
4 **TX_PVLS** Patient retained in treatment	NA	80.0%	/	/	/	TBD	?
5 TX_RET Patient in treatment with vira load suppressed	NA	85.0%	/	/	/	TBD	?

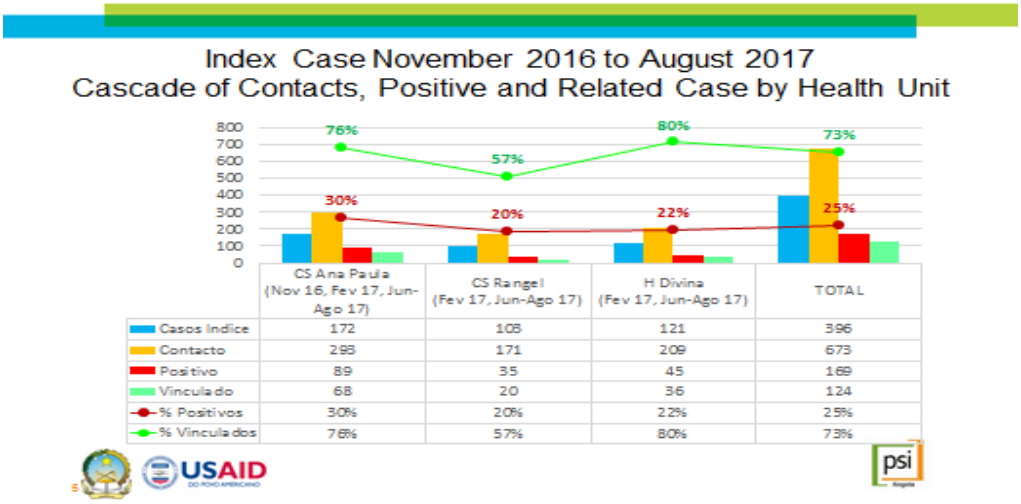
3.3 Reasons for over/under achievements:

- **HTS_TST:** In FY1, the project reached 68,494 individuals with HIV Testing Services, representing **138%** of the target (49,372). This largely reflects the success of the project's strategies to allocate several testing points in each health unit, and provide collective and individual counseling through the PAFs (Patients Assistant Facilitator & peer educator). Supervision is very important to guarantee the improvement of data registry by health staff and improve the quality of implementation of testing activities.
- **TX_NEW:** The achievement of 3,695 new patients on treatment represents **63%** of the target (5,816). Constraints to achievement of this target were: (1) Angola had not yet adopted the Test and Treat strategy, and (2) health staff could only initiate patients on treatment based on a number of clinical factors (including WHO Clinical Stage, CD4 count, other lab tests, etc.). Individual follow up by the PAFs (Patients Assistant Facilitator and Peer educator) including active search and linkage to Care and Treatment will contribute to the progressive increase in the number of new patients in treatment.

- **TX_CURR:** 23,067 patients in treatment during the FY1 represent **90.7%** of the target (25,417). The Index Case Testing and Tracing will help to increase the number of HIV+ cases and consequently increase the number of new cases in treatment and current treatments.
- **TX_RET:** The annual percentage of patients retained on treatment is yet to be defined (Target 80%).
- **TX_PVLS:** The annual percentage of patients on treatment with viral load suppressed is yet to be defined (Target 85%).

3.4 Index Case Testing & Tracing (ICTT):

During FY1 (2017), HFA/MSH re-started the Index Case Testing and Tracing, initiated as a pilot project by SASH in November 2016 and finished in February 2017. HFA implemented ICTT in the same three HUs as the pilot (Ana Paula, Rangel and Divina). The table below presents the number of index cases and contacts tested, as well as the percent of positive cases among contacts per facility.



The success of this strategy is due to the excellent work done by the Community Counselors (CCs) and strong coordination with HU staff. The percentage of positive cases identified through traditional testing in the HU is around 10%, whereas in ICTT it is around 30%.

3.5 Major Constraints and Solutions:

- *Lack of implementation of the Test & Treat strategy*: MoH through INLS will start the strategy as a Pilot Project in 24 Hus, including the 9 PEPFAR assigned Hus, planned to start on November 15th.
- *Lack of Reagents (Determine/Unigold) for periodic testing*: HFA and PSM (Procurement Supply Management Project) have started regular meetings to better coordinate the stock in the different testing points in the HUs. HFA will continue to advocate with the MoH to avoid lack of testing reagents at central level.
- *Lack of skilled health staff in the HUs to initiate the TARV process*: at present only medical doctors can open the TARV process. It'll be necessary to empower and authorize skilled trained nurses to help in this activity.
- *Lack of basic supplies (cotton, gloves, alcohol, etc.) to carry out the tests*: HFA and PSM have to more strongly advocate with MoH/INLS to avoid stopping testing activities by lack of basic supplies.
- *Lack of a common and unified informatic system in the nine HUs*: HFA has been convening coordination meetings in an attempt to unify the Informatic System with all stakeholders involved in activities in the HUs.

- *Existence of some management issues in the HIV/AIDS Services at three of the HUs (Esperanza, Divina Providencia, and Hospital Pediatrico)*: Esperanza is a referral HU that depends exclusively on INLS for its management and SIS, which differs from the other HUs. Divina Providencia is a mixed HU: half private (run by an International NGO) and half public with support from the MoH. Hospital Pediatrico has HIV/AIDS service only for children under 14 years old. Together with INLS, HFA has been debating the situation of Esperanza and Divina with their Directors to find a coordinated solution to unify activities with the rest of the HUs. With Hospital Pediatrico, HFA through their PAFs will follow all adult patients and refer them to Dispensario HU to continue the process.

3.6 Recommendations for FY2:

FIRST 90: 90% of all people living with HIV will know their HIV status

- Continue the incrementation of Index Case Testing and Tracing in the nine PEPFAR assigned HUs (Community Counselors' activity).
- Improve the quality of the Testing Points and reduce to a minimum those that don't achieve the basic priority requirements in the nine PEPFAR assigned HUs, according with the results of the last assessment done by AFENET and HFA.
- Strongly consider testing patients in the inpatient medical wards (adult and children) with severe symptoms and/or signs of immune-depression.
- Consider testing 100% of TB and malnourished patients.
- Ensure high quality post-test counseling to ensure that patients are not stigmatized and know of the benefits of ART for them and their loved ones (PAF's activity).
- Ensure that first adherence counseling is also high quality and addresses positive aspects of treatment (PAF's activity).
- Ensure active linkage from HIV Testing Services to ART clinics (PAF's activity).
- Work with LINKAGES project on Key Populations (KP) for testing to ensure active linkage of HIV+ patients from the community to ART clinics.
- Focus on populations and locations with high positivity rates, but also on entry points with high numbers of HIV positives, to increase the number of identified positives.

SECOND 90: 90% of all people with diagnosed HIV infection will receive sustained TARV

- Increase the number of new patients on treatment with the implementation of the strategy **Test & Treat**. Consolidate the results of the assessment done by INLS on the 24 HUs involved in the strategy, including the nine PEPFAR assigned HUs.
- Immediately include all HIV+ patients in Pre-TARV to ART clinics according to feasibility of each HUs.
- Implement task shifting to ensure that enough health staff are skilled and trained to initiate ART (not only medical doctors).
- Reduce the frequency of ART pick-up for patients on treatment by offering multi-month scripting (3 or 6 months) to stable clients.
- Use community health workers to deliver ARVs to the patients in the community who have some inconvenient to pick them up at the Health Unit.
- Follow up on the "one stop-shop" strategy procedure for ART and TB treatment for co-infected patients.
- Ensure that registration for both TB and HIV happen in both locations.
- Test all TB suspects, not just confirmed infected ones.
- Continue with active defaulter tracing to improve retention (PAF's activity) and promote and disseminate GAM (*Grupo de Ajuda Mutua*) established in two Health Units to help the most vulnerable HIV patients in adhesion and retention to TARV and improve their nutrition.

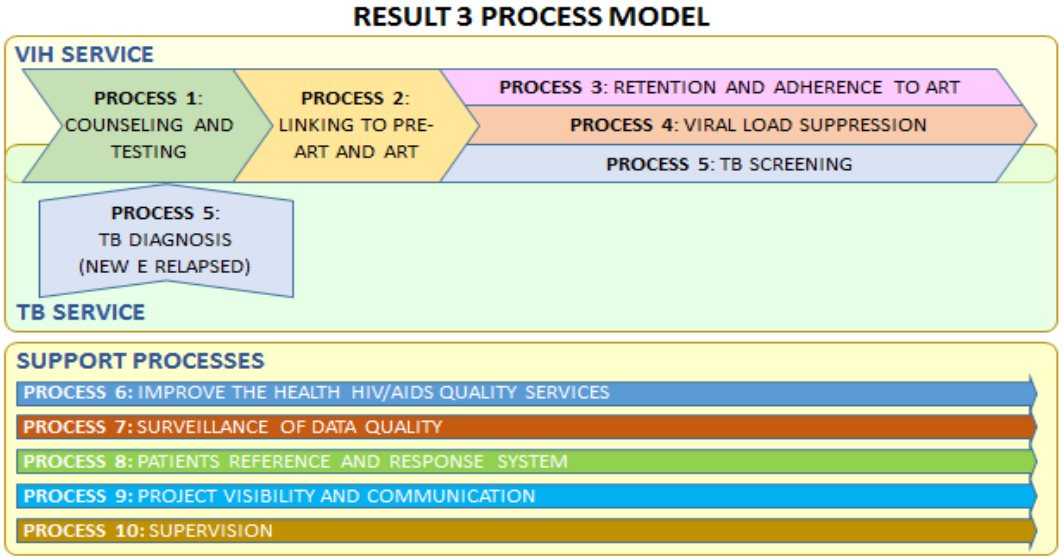
THIRD 90: 90% of all people receiving TARV will have viral suppression

- Consider using GeneXpert for Viral Load Test (approved by WHO).
- Consider purchasing reagents for GeneXpert Virus Load tests.
- Ensure adherence counseling at every visit and the importance of Viral Suppression.

3.7 Proposed Targets for FY2:

Implementing Mechanism	18347_HFA	
Indicator Code	**Frequency of Reporting**	**COP17 Target**
HTC_TST	Quarterly	43,845
HTC_TST_POS	Quarterly	5,843
TX_NEW	Quarterly	7,543
TX_CURR	Quarterly	22,003
TX_TB Num	Semi-Annual	918
TX_TB Den	Semi-Annual	18,615
TB_Prev Num	Semi-Annual	1,954
TB_Prev Den	Semi-Annual	2,836
TB_STAT Num	Semi-Annual	4,005
TB_STAT Den	Semi-Annual	4,682
TB_ART Num	Semi-Annual	673
TB_ART Den	Semi-Annual	750
TX_RET Num	Annual	4,027
TX_RET Den	Annual	5,035
TX_PVLS Num	Annual	9,206
TX_PVLS Den	Annual	11,513

To achieve the targets for FY2 (2018), MSH designed the **Process Model** (below), which includes five strategic processes and five transversal support processes. This model covers the entire set of activities of the Continuum of Care (COC) in the seven HUs assigned to HFA. They are: Testing, Linking to Care and treatment, Retention and Adherence to ART, Viral Load Suppression, and TB Screening and Diagnosis (New & relapsed). It also includes five processes of support to COC activities. They are: Improve the health HIV/AIDS quality services; Surveillance of data quality; Patients referral and response system; Visibility and Communication and Supervision.



In addition to the **Process Model,** HFA/MSH is scaling up Index Case Testing and Tracing from three Health Units (Viana, Rangel y Divina) to all seven HUs assigned to HFA (new sites include Kilamba, Dispensario, Esperanza, and Pediatrico). This will increase the numbers of HIV+ persons identified and consequently will increase the entire cascade of care.

3.8 Environmental Mitigation Plan FY1 (2017)

Health for All – Quarter 4 Report (FY17)
EMMP

Results 3: Sustainable models for providing high-quality in HIV/AIDS services

Indicators	Achieved		
	Q3	Q4	Total
1. Number of SOPs *revised/developed* to improve stands for HIV care and treatment services in 9 PEPFAR facilities	ICAP	ICAP	ICAP
2. Number of facility staff *trained* on the use of SOPs by HFA on HIV/AIDS Services	13	27	40
3. Number of trained staff *supervised* on the use of SOPs by HFA on HIV/AIDS Services	62	99	161

1. Per PEPFAR Guidance, the revision and development of SOPs to improve standards for HIV care and treatment services is the responsibility of ICAP.
2. The number of facility staff trained by HFA/MSH on HIV/AIDS services in the nine Health Units is 40. These trained staff include personnel from HFA (PAFs, CMs and CCs) and the target Health Units.
3. The number of trained staff supervised in the nine Health Units within the HIV/AIDS services is 161. The supervision includes the entire number of Testing Points in the Health Units, linkage to the first consulting and the activities of the Community Counselors on Index Case.

Result 4: Strengthened, Expanded and Integrated Sexual Reproductive Health and Family Planning Services at Provincial, Municipal Levels

4.1 Background:

During Year 1 of the project, in collaboration provincial authorities, the HFA team conducted supervision in health facilities with Family Planning Services in Luanda and Huambo provinces, as a continuation of SASH program. A total of 101 health facilities were visited in Luanda and 17 in Huambo. These visits helped the team to understand the overall picture of health units: (a) identify constant stock out of family planning methods; (b) identify the capacity building needs at both provincial and municipal levels; (c) insufficient number of methods distributed in the province, which conditions the delivery of methods to users; and (d) lack of data collection material (book of record, user registration forms, registration cards, lack of daily and monthly reporting model).

To minimize the identified problems, HFA, in collaboration with UNFPA and DNSP, conducted two trainings: one in Luanda (on Sayana Press and Noristerat), in which 26 focal points on Family Planning participated, and another one in Huambo, which was a refresher training on Long Acting Reversible Contraceptive (LARCs) Family Planning methods, with the participation of 16 municipal focal points.

During the same year, HFA held several meetings with the local implementing partner Rede Mulher Angola (RMA) to better understand their capacity and needs to manage implementation of activities related to Social Behavior Change and Communication (SBCC) for community interventions in Luanda and two other provinces. To Strengthen the capacity of RMA, HFA conducted a SBCC training focusing on Sexual Reproductive Health and Family Planning, attended by 12 participants, including RMA staff and member organizations.

A mapping process of public health facilities (HF) was also completed in FY17. A total of 192 HF were found in Huambo province, among which 99 offer FP services. In Luanda, a total of 162 HF were found, with 108 offering FP services. The higher number of HF providing FP services in Luanda is due to the size of the population, the number of trained professionals and availability of commodities. In FY2, the list of health facilities will be updated, if needed, in cooperation with GEPE and the Department of Reproductive Health/MoH.

The tables below represent the number of HF mapped by municipality in each province:

Luanda Province

Municipalities	# of Total Health Facilities	# of Health Facilities with SRH/FP services
Cacuaco	**19**	**21**
Cazenga	**11**	**8**
Icolo e Bengo	**22**	**4**
Luanda e belas	**69**	**54**
Kissama	**16**	**2**
Viana	**25**	**19**
TOTAL	**162**	**108**

Huambo Province

Municipalities	# of Health Total Health facilities	# of Health facilities with SRH/FP services
Bailundo	**24**	**11**
Ecunha	**11**	**11**
Huambo	**55**	**26**
Caála	**14**	**9**
Catchiungo	**24**	**1**
Londuimbali	**14**	**14**
Longonjo	**11**	**1**
Chicala-Tcholohanga	**8**	**5**
Mungo	**11**	**11**
Tchinjenje	**9**	**9**
Ucuma	**11**	**1**
TOTAL	**192**	**99**

4.2 Summary of Major Achievements:

In Q4, 35 health facilities (HF) were visited in Luanda. In FY01, HFA supervised only the HF that SASH had previously supervised, and confirmed that they offer Family Planning (FP) services. During the whole of Y1, a total of 57 HF were visited in Luanda and Huambo.

No HF was found to be in a complete stock out of contraceptives. Due to a collaborative work between PSI and PSM, it was possible to obtain information on contraceptive stock at the provincial level. This collaboration helped to support contraceptive trading among provinces. For instance, provinces that did not have Intra-Uterine Device (IUD) but had condoms were able to exchange condoms for IUDs or other contraceptives with the provinces that had IUDs (other contraceptives).

This allowed to maintain at least some stock of contraceptives in both provinces. Nevertheless, to better monitor contraceptive availability, future reports will describe the stock level per contraceptive. Regarding training, 101 health professionals were trained in Y1. Among the trainees, 42 were health providers who received a refresher training on FP service delivery and a new training on Sayana Press and Noristerat.

IR4: Activities (Luanda & Huambo) *							
Performance Indicators	**Baseline 2016**	**Target 2017**	**Achieved**				**Achieved/ Target**
			Q2	**Q3**	**Q4 ****	**Total**	
Percentage of USG-assisted service delivery points (SDPs) offering FP/RH counseling or services	59.5%	59.5%	-	58.6%	58.6%	58.6%	**98.5%**
Percent of USG-assisted service delivery points that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide	6.7%	6.7%	-	0	0	0	0%
Couple years protection in USG supported programs	59,054	59,054	-	29,729	4,313	34,073	68%
Number of health care workers who successfully completed an in/service training program	192	26	-	26	16	42	161.5%
Number of people trained with USG funds	307	60	-	0	59	59	98.3%

4.3 Reasons for over/under achievements:

- In Luanda, the targets in supervision were achieved due to close cooperation with the Provincial Health Department and FP/RH Focal Points, who facilitated supervision visits to the health facilities and provided statistical information when requested. The Provincial Health Department of Luanda also supported the training on FP service delivery that was co-organized with UNFPA.
- In Huambo, there were some shortfalls. The lack of a quality assurance supervisor, as well as the poor involvement of the Provincial FP/RH Focal Point prevented HFA from supervising the intended number of target HF.

4.4 Major Constraint and Solution:

There is an inconsistency in data collection due to use of different tools among target HF in Huambo and Luanda, which may have an impact on the number of DALYs reported. Some HF are not filling thoroughly the reports and there is a constant delay in the reporting data due to logistic reasons, such as lack of transportation, etc. Efforts are being made with the Provincial Health Departments of Luanda and Huambo to overcome this issue.

4.5 Recommendations for FY2:

- High level advocacy for the inclusion of contraceptives and other SRH products in the Government General Budget.
- Standardize and train healthcare providers on correctly and timely filling statistical forms.
- Use of electronic report system, which does not require health care providers to travel 80 kilometers or more to deliver statistics.
- Include men in the communication activities to improve FP uptake among couples.

4.6 Proposed targets for Y2:

Indicator Type: Standard Indicators		FY16 Baseline (PSI Survey/ DHS/SASH)	Target for FY18	List of main activities
A4.1	Indicator: Percentage of USG-assisted service delivery points (SDPs) offering FP/RH counseling or services	**59.5%**	**59.5%**	Providing refresher trainings to FP healthcare providers
A4.2	Indicator: Percent of USG-assisted service delivery points that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide	**6.7%**	**6.7%**	Provide Supportive supervision to USG-assisted service delivery points (SDPs)
A4.3	Indicator: Couple years protection in USG supported programs	**59,054**	**59,054**	
A4.4	Indicator: Percentage of health facilities whose providers reported a Quality of Care score >= 80% for management of FP services (+)	**N/A**	**40%**	Providing refresher trainings to FP healthcare providers
A4.5	Indicator: Number of health care workers who successfully completed an in/service training program	**192**	**280**	Providing refresher trainings to FP healthcare providers
A4.6	Indicator: Number of protocols finalized and approved	**4**	**4**	Working directly with DNSP to create or finalize protocols
A4.7	Indicator: Number of people trained with USG funds	**307 (not defined)**	**400 (non-health workers)**	Providing trainings to key personnel from DPS
A4.8	Indicator: Number of USG-assisted community health workers (CHWs) providing Family Planning (FP) information, referrals, and/or services during the year	**N/A**	**30**	Providing refresher trainings to FP healthcare providers

4.7 Environmental Mitigation Plan FY1 (2017)

Activities under IR4 in regards to EMMP have a status of categorical exclusion and do not require reporting.

Result 5: Capacity of Municipal and Provincial Governments to Plan, Fund, Monitor, and Supervise Health Programs Improved

5.1 Background:

Under this component, USAID defined the main topics to be prioritized and geographical areas of interest, as follows:

- Strengthen municipal capacities in annual planning and budgeting.
- Strengthen capacities of the NMCP in annual planning, budgeting, job descriptions, financing management, and assessment/diagnosis of NMCP interventions.
- Strengthen capacities for costing iCCM (Integrated Community Case Management) interventions (initially malaria, and later for diarrhea and pneumonia).

At the beginning of FY1, USAUD/PMI requested HFA to only start supporting provincial and municipal plans, budgets and management monitoring at DPS level and 10 municipalities (DMS) in the provinces of Zaire and Lunda Sul in Year 2.

5.2 Summary of Major Achievements:

In regard to strengthening the **Health Management Information System** through **DHIS2**, the following achievements took place during FY1:

- PSI was instrumental in providing support to the development of the Terms of Reference for the DHIS2 Technical Working Group (jointly with PMI and other partners).
- Based on a model received from PMI, PSI assisted in the development of the first draft for the DHIS2 Roadmap, including budget and chronogram, disaggregated by provincial, municipal and health facility (HF) levels.
- The first draft of the DHIS2 Roadmap was shared with GEPE-GTI, who used it in the preparation of a draft Roadmap for DHIS2 at national level. The definitive version was then used by all DHIS2 TWG partners.
- An expert on DHIS2 is in final stage of recruitment, after going through an extensive selection process, which included screening and interviewing 36 candidates by a panel of experts from PSI. The selected candidate will start in the new position in the first quarter of FY2.
- Ricardo Yava, the HFA M&E Advisor on malaria, was seconded to the NMCP to provide support in developing the Malaria Strategic Plan and a Concept Note for the Global Fund.
- In close coordination with GEPE-GTI, PSI elaborated the DHIS2 Dashboard and proposed a program agenda and list of invitees for a workshop for the development of the National DHIS2 Plan, that is taking place in Luanda between 23-26 of October/17.
- Implementation of the Therapeutic Efficacy Study led by CDC in three provinces: Benguela, Lunda Sul and Zaire. The study measured the efficacy of three antimalarials in children under five years: DP, AL, and ASAQ. In total 2,593 children were trialed, 608 were enrolled and 540 completed the study. Results will be presented by CDC. The study took place during Q3 and Q4 2017.

5.3 Major Constraints:

- Negotiations between the NMCP and USAID to start the implementation of capacity strengthening activities are still ongoing;
- The budget allocated for Governances Activities (planning, budgeting) at local level is very limited to provide technical assistance to Zaire and Lunda Sul. HFA must find creative and innovative strategies to reach the results expected.

5.4 Recommendations for FY2018:

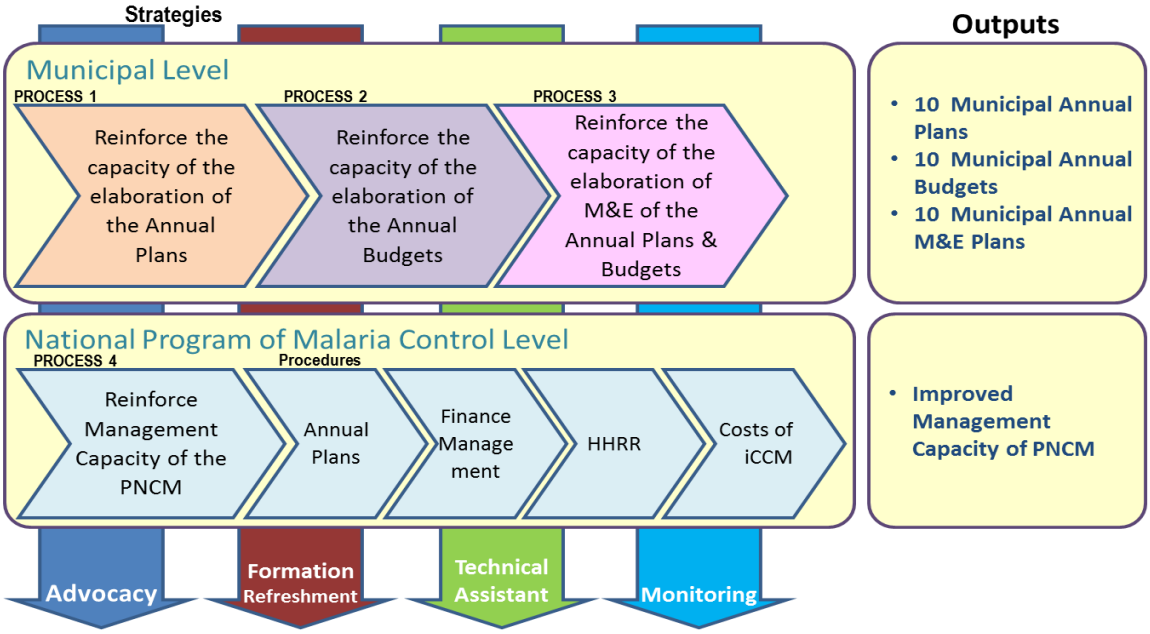
- Align outputs of the planning and budgeting process at municipal and provincial level to the development and implementation of DHIS2. Indicators identified on the planning and budgeting processes will become inputs for DHIS2.
- Identify challenges to be faced by the MoH when implementing the planning-budgeting tool (FPOM – *Ferramenta de Planificação, Orçamentação e Monitoria*). Key information to be processed by FPOM could be inputs for DHIS2.

5.5 Proposed targets for FY2:

Finance and Governance Strengthening

In FY2, HFA will start the implementation of cross-cutting activities at the local level to support specific interventions related with malaria, HIV and family planning/reproductive health at provincial and municipal levels. USAID Angola has recommended the involvement of the provincial and municipal health authorities DPS (Provincial Directory of Health) and DMS (Municipal Directory of Health).

HFA has defined four big processes to be implemented in FY2, but the most important will be to focus on the outputs or deliverables expected: 10 municipal annual plans and budgets, 2 provincial annual plans and budgets, M&E plans and management capacities of NMCP improved.



- **Annual operating plans capacities improved at selected DMS (Municipal Directory of Health)**

As per MOH–GEPE (Studies, Planning and Statistic Cabinet) request to USAID, HFA will provide training and technical assistance with the **planning tools** currently used by other partners, like the Europe Union and The World Bank Projects. The municipal AOPs will incorporate HFA's focus areas to provide sustainability and continuous support to all selected areas, like malaria, HIV, and FP services.

- **Strengthening budget capacities at selected DMS**

HFA will provide technical assistance to strengthen budget management capacities at the municipal and provincial level. Since budget ceilings probably will not be increased and may potentially be reduced, the best thing that can be done at the municipal and provincial level is to improve the control of the resources allocated to each entity. HFA will conduct provincial workshops (in Zaire and Lunda Sul) with the ten municipalities and two provinces to carry out budgets. In the process of development of municipal and provincial budgets, HFA will guarantee involvement of at least four municipal technicians from each RMS, totaling 48 officials to be trained on budget formulation and implementation of financial best practices. This training process and technical assistance will help prepare the municipal teams for the development of the Public Budget for Year 2019. HFA will implement, at the end of the process, a session to share the Municipal Budget results with provincial, municipal, and MOH–GEPE authorities.

- **Strengthening monitoring capacities at selected DMS**

In FY2, HFA will develop tools to oversee both municipal Annual Operational Plans (AOPs) and budgets to implement a process of strengthening local capabilities at municipal level to ensure their AOPs implementation. This monitoring will ensure that the activities programmed in each AOP will be implemented. Through routine reviews, HFA will also verify whether specific results are achieved using indicators for the different objectives established in the AOP.

This process will require training in the use of specific tools at the municipal level, as well as monthly technical support to guarantee appropriate measurement and interpretation of indicators, and then choosing the corrective intervention required. As such, HFA will provide technical assistance to conduct monthly meetings by municipality to help them monitor budget implementation. Based on analyses of reported expenditures from each DMS, it will be possible to compare resources allocated versus resources spent. By doing so, the DMS will be able to identify gaps and recognize which program needs to be allocated more resources, or which health unit should be prioritized.

- **Strengthening management capacities of the National Malaria Control Program**

HFA will provide TA to strength management capacities of the National Malaria Control Programs (NMCP), such as capacity to carry out annual operating plans, develop appropriate budgets, and improve finance management, human resources management (e.g. job descriptions and performance evaluation).

The NMCP has a current Strategic Plan 2016-2020, but the next stage of development will be the development of Annual Operational Plans (AOP), and monitoring of strategies and key activities implemented. In addition, according to recent institutional analysis which found some gaps, NMCP requested technical assistance (TA) for capacity strengthening in the development of a comprehensive institutional assessment (probably using MOST/MSH tool), to then start procedures to improve management capacities on finance and human resources systems.

HFA will provide technical assistance to strength capacities for costing iCCM (Integrated Community Case Management) interventions. This strategy (piloted by World Vision) is currently being implemented in some municipalities of three provinces: Lunda Norte, Moxico and Malanje. In response to USAID's request, the initial focus will be a phased costing exercise, starting with malaria interventions (early 2018), then diarrhea and later pneumonia (later 2018 or early 2019).

Finally, HFA will promote a broad meeting with MOH, NMCP and DPS authorities to share findings and recommendations of the costing analysis.

Health Information System Strengthening

During FY2, HFA will continue participating in meetings with the DHIS2 Technical Working Group led by GEPE/GTI to work on the National DHIS2 Roadmap. The roadmap will prevent duplication of efforts with partners working on the same geographic or health areas, and will serve as a joint planning and accountability tool. The roadmap will also enable GEPE-GTI and its TWG to track progress and come up with solutions to any problems encountered during the DHIS2 deployment.

With support from PMI, HFA will also lead a workshop on October 2017 with all partners to finalize the National Roadmap for DHIS2, bringing on board PSI/Global experts and local staff. HFA will coordinate and work closely with the PSM project, who leads on the eLMIS system, so that the integrated HMIS system is developed and implemented in Angola from the start.

Based on the Roadmap developed and validated at the Roadmap workshop, by the end of FY2 Q1, HFA will have developed a detailed DHIS2 implementation plan that will be executed along the year. After the system is completely set up, an evaluation of the DHIS2 platform will be programmed to adjust for improvement and fix errors.

5.6 Environmental, Monitoring and Mitigation Plan:

The HFA project received approval from USAID of its Environmental Mitigation and Monitoring Plan during Q1 2017. Under IR5, one indicator associated to the TES study received negative determination, meaning that some measures needed to be implemented to mitigate the low/moderate impact to the environment.

In that regard, the TES personnel received training on how to manage biological and hazardous waste in accordance to the MOH standard operational procedures.

During fieldwork a total of 30 staff members (2 doctors, 4 nurses and 4 lab technicians per province) followed the MOH procedures of management and discharge of biological waste: placed used lancets and other biological waste in biological safety boxes, after which all material was collected and sent to an incinerator.

All other activities under R5 received *categorical exclusion determination*, meaning no action needed to take place, since it was considered that they had no impact on the environment. Below a table with the referred indicator with negative determination.

Monitoring Indicator	Mitigation Measure	Q2	Q3	Q4	Total
# of test personnel using SOP correctly	Study personnel (lab tech, supervisors) will use MOH SOPs in managing biological and hazardous waste at the provincial health facilities where study activities will take place	N/A	30	30	30 (same staff)

Luanda, October 31st, 2017.

SUCCESS STORY

"ENGAGEMENT ENHANCES PERFORMANCE"

Photo Credit: USAID/Angola

ITN distribution activity, May 2017

... "the strategy of work for the campaign not only increased the dynamics of malaria prevention in the province but also established a requirement for collaboration among provincial partners, including community leaders who have been significantly contributing for the flow of activities at community level".

Félix Espalhado, malaria program supervisor, Cuanza Sul Province.

U.S. Agency for International Development
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Cuanza Sul, like other parts of Angola, is an endemic malaria region. Despite being considered meso-endemic, malaria continues to be a health concern in Cuanza Sul, especially at a time when the province sees its resources reduced for malaria activities. Data advanced by Cuanza Sul Provincial Health Department (CSPHD) showed 236.515 cases of malaria with 12.853,00 hospitalizations and 707 deaths in the first semester of 2017. With the current economic crisis in the country, many projects have been closed and CSPHD has been struggling with the challenging task of sustaining malaria control activities in the province. That is why CSPHD strongly applauds the novel campaign of massive Insecticide Treated Nets distribution adopted by the National Malaria Control Program (NMCP) through USAID / PMI funding. Mr. Felix Espalhado, the CSPHD provincial malaria program supervisor, enthusiastically said that "*for the CSPHD it is an honor to be part of the first 5 provinces to lead a simultaneous mass distribution campaign in Angola*". For him, "*the strategy of work implemented for the campaign not only increased the dynamics of malaria prevention in the province but also established a requirement for collaboration among provincial stakeholders, including community leaders who have been significantly contributing for the flow of activities*". While recognizing the great challenge of leading several activities simultaneously in all municipalities, Mr. Espalhado also praised the various strategic actions that stimulated the active involvement of all partners, with emphasis on the macro and microplanning exercises led by CSPHD and PSI Angola- the NMCP's partner in the implementation of the campaign. It allowed CSPHD and PSI Angola to gather contributions at various levels including rooms for training rooms and administrative work, transportation, accommodation, and warehouses besides facilitating the compliance with the schedule as proposed. In 3 months, 1,974 community health workers were trained by PSI Angola on malaria counselling and campaign tools to carry out the activities of communication, registration and distribution of mosquito nets and; 990.944 ITNs were distributed to 1.720.325 people in all municipalities. According to Mr. Espalhado, "*this new dynamic of work was a learning process for the province and with this the CSPHD hopes to have positive and sustainable impacts, counting on reinforcement of social behavior change communication programs to promote the use of the mosquito nets received and with the continued participation and contribution of all the provincial stakeholders involved in the fight against malaria. It was even an opportunity for everyone to realize their important role in improving the province's health conditions.*"

SUCCESS STORY

"Tracing HIV contacts, saving lives…"

USAID Health for All Project is having success tracing HIV contacts at community level.

Eva Hadi Dos Santos, Community Counselor and Suzeth de Morais, Patient Assistant Facilitator from Viana Health Center. Luanda Angola. Photo: Health for All Project – USAID / Angola

"I was very happy and fulfilled for helping this family." Eva Hadi Dos Santos, Community Counsellor - Viana Health Center, Luanda, Angola.

**Name has been changed to protect confidentiality.*

It happened on July 10, 2017 at the Viana Health Center (HC), one of the nine health facilities supported by the President's Emergency Plan for AIDS Relief (PEPFAR) in Luanda, Angola. Maria*, a young mother, brought her 15 month-old child seeking care for severe malnutrition. In accordance with clinical guidelines, the child was tested for HIV by the Counseling and Testing Service, and was identified as HIV positive. Immediately, Maria was also tested and was found to be HIV positive.

The Health for All (HFA) Project, funded by the U.S. Agency for International Development (USAID) and implemented by Population Services International with support from Management Sciences for Health (MSH), supports efforts to link HIV positive individuals with appropriate care through counseling and contact tracing, an important strategy to maintaining progress in controlling the HIV and AIDS epidemic in the country. Patient Assistant Facilitator, Suzeth de Moráis António, introduced the case to Eva Hadi Dos Santos, a Community Counselor supported by the USAID HFA Project, who initiated counseling and support for Maria. She encouraged her to speak to her husband and family, and provided her phone number to ensure Maria could reach her.

Maria was very worried about the health condition of her child, and in addition, she lacked the courage to face her husband with the news of their diagnosis. Key to the success of this strategy is that the Community Counselor presents to the client the advantages of revealing their status to their partner and supports their decision-making.

Later that day, after counseling, Eva Hadi received a phone call and she heard the tremulous voice of Maria requesting her to quickly go to her house as Maria's husband had tried to kill himself at home. Eva Hadi asked to speak with her husband, Carlos, and managed to keep him calm until she arrived to their home.

She counseled the couple, explaining the stages of HIV and the differences between HIV and AIDS. She discussed topics including transmission, the possibility of being a discordant couple, what HIV meant for their child, and the advantages of appropriate care and treatment. Eva Hadi's counseling stressed the importance of support between them, and reassured her support and confidentiality to protect them from stigma or discrimination. She also provided counseling on proper nutrition practices, and supported the couple as they struggled with breastfeeding and incorporated formula feeding.

Soon after, Carlos consented to be tested and his result was negative. Overjoyed by his diagnosis, he committed himself to care for his wife and young child, thanks to the support from Eva Hadi. Three weeks later, Carlos and Maria returned to Viana HC for a scheduled consultation. The child had recovered from malnutrition, was feeding well, and gaining weight.

USAID's HFA Project supports Community Counselors across three health centers in Luanda, each of them extending care to the community and increasing access and uptake of HIV services.