HEALTHFORALL

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

ACRONYM LIST

ACT	Artemisinin-based Combination Therapy
ADECOS	*Agentes de Desenvolvimento Comunitário e Sanitario* (community health workers)
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
CHW	Community Health Worker
CoC	Continuum of Care
COP	Chief of Party
CPR	Contraceptive Prevalence Rate
CSC	Contraceptive Security Committee
DHIS2	District Health Information Software 2
DHS	Demographic and Health Survey
DHP	Dihydroartemisinin-piperaquine
DNSP	Direcção Nacional de Saúde Pública (national public health department)
DPS	*Direcção Provincial da Saúde* (provincial health department)
EMMP	Environmental Monitoring and Management Plan
FP	Family Planning
FP/RH	Family Planning and Reproductive Health
GF	Global Fund (GFATM)
GRA	Government of the Republic of Angola
HH	Household
HF	Health Facility
HFA	Health for All
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNQIS	Health Network Quality Improvement System
HSS	Health Systems Strengthening
HTS	HIV/AIDS Testing Services
HU	Health Unit
HW	Health Worker
iCCM	Integrated Community Case Management
INLS	Instituto Nacional de Luta Contra a SIDA
IPC	Interpersonal Communication
IPTp	Intermittent Preventive Treatment in Pregnant Women
IR	Intermediate Results
LLIN	Insecticide-treated Net
IUD	Intrauterine Device
KP	Key Population
LARC	Long-Acting Reversible Contraception
LLIN	Long-Lasting Insecticidal Net
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MENTOR	The MENTOR Initiative
MIP	Malaria in Pregnancy
MOH	Ministry of Health
MSH	Management Sciences for Health

NGO	Nongovernmental Organization
NMCP	National Malaria Control Program
PAC	Post-Abortion Care
PAF	Patient Assistant Facilitator
PAFP	Post-Abortion Family Planning
PBCC	Provider Behavior Change Communication
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living With HIV
PMI	United States President's Malaria Initiative
PMP	Performance Management Plan
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public-Private Partnership
PSI	Population Services International
PSI/A	PSI/Angola
PSM	Procurement and Supply Management Project (GHSC-PSM)
QA	Quality Assurance
RH	Reproductive Health
RHWG	Reproductive Health Working Group
RMA	Rede Mulher Angola
RDT	Rapid Diagnostic Test
SBCC	Social and Behavior Change Communication
SOP	Standard Operating Procedure
SP	Sulfadoxine-pyrimethamine
SPBCC	Supervisor Provincial de Promoção da Saúde
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendants
TH	Tropical Health, LLP
ToT	Training of Trainers, Trainer of Trainers
TSA	TecnoSaúde Angola, SA
TWG	Technical Working Group
UC	Universal Coverage
UNAIDS	Joint United Nations Program on HIV and AIDS
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization
WHP	Women's Health Project

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YEAR 2 – QUARTER 2 (JAN-MAR 2018)

In January 2017, a 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. The following report describes main achievements per Objective/Expected Result that happened between January 1st and March 31st, 2018 (2nd Quarter of Year 2 or FY18).

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

1.1 Background

Malaria is an endemic disease in Angola and considered one of the main public health concerns; it is the main cause of death and hospitalizations, affecting mainly pregnant women and children under the age of five years old in all regions of the country. To reverse this situation, the Angolan government is strongly investing in prevention methods, including Long Lasting Insecticide-treated Nets (LLIN), which is considered one of the most effective ways to prevent malaria. Through the USAID-funded Health for All project (HFA), the National Malaria Control Program (NMCP) aims to achieve universal coverage and increase access and use of LLINs to 80% nationwide. Under the leadership of NMCP, HFA is the main implementing partner of the LLIN distribution campaign in coordination with PSM, which is in charge of the placement of mosquito nets (prepositioning) in the target provinces and respective municipalities. The LLIN distribution campaign is implemented by phases in several provinces simultaneously. Phase 1 and phase 2 have already been concluded (FY17), followed by phases 3 and 4 until the end of FY18.

1.2 Targets for FY18:

Since there were changes in the availability of LLINs after the end of phase 2 (Q1 FY17), the targets for FY18 had to be adjusted, according to the new agreement with NMCP/DNSP, PMI/USAID and partners, which includes distributing nets in Huambo (not previously planned) and removing Cabinda, Bie and Bengo from phase 3 of the distribution. The table below reflects such changes:

Quarter	Province	Population in 2018	LLINs need	nº of households	nº of children under 5	nº of Pregnant Women
Q1	Cunene	1 121 748	623 193	243 858	217 395	27 819
	Namibe	568 722	315 957	123 635	110 218	14 104
	Sub total	1 690 470	939 150	367 493	327 613	41 923
Q2	Huambo	2 309 829	1 283 238	502 137	447 645	57 284
	Sub total	2 309 829	1 283 238	502 137	447 645	57 284
Q3	Cuando Cubango	854 258	474 588	185 708	165 555	21 186
	Moxico	601 454	334 141	130 751	116 562	14 916
	Sub total	1 455 712	808 729	316 459	282 117	36 102
Q4	Lunda Norte	972 183	540 102	211 344	188 409	24 110
	Lunda Sul	609 851	338 806	132 576	118 189	15 124
	Sub total	1 582 034	878 908	343 920	306 598	39 234
TOTAL FY18		7 038 045	3 910 025	1 530 009	1 363 973	174 543

1.3 Major Achievements during Q2 FY18:

As a result of the long delay for a final definition on which LLINs to be used for phase 3 of the Mass Distribution Campaign, the results achieved during this reporting period were directly affected, with no distribution taking place between January and April 2018.

For that reason, the initially proposed targets for FY18 (presented in the FY18 Workplan and also in the FY18 Q1 Report) had to be revised (see table below). The last column of the table shows consolidated achievements (Q1 + Q2) against the modified year targets up to 31st March 2018.

Performance Indicators	Baseline	Target	Quarter targets for FY18				Achieved in Quarters 1+2/ Year target
	2015-16	2018	Q1	Q2	Q3	Q4	
1. Number of insecticide treated nets (LLINs) that were distributed in this reported fiscal year.	1,739,431	**3,910,025**	939,150	1,283,238	808,729	878,908	796,257 + 0*/ **3,910,025 (20.4%)**
2. Number of community HWs trained in counseling on LLIN use in this reported fiscal year.	399	**4,653**	1,102	1,478	1,026	1,047	931 +0*/ 4,653 **(20.0%)**
3. Number of households with at least one LLIN for every two people in this reported fiscal year.	106,864	**1,530,009**	367,493	502,137	316,459	343,920	240,971 + 0*/ 1,530,009 **(15,8%)**
4. Number of Children < 5 covered with LLIN in this reported fiscal year.	187,944	**1,363,973**	327,613	447,645	282,117	306,598	210,488 +0*/ 1,363,973 **(15,4 %)**
5. Number of pregnant women covered with LLIN in this reported fiscal year	25,490	**174,543**	41,923	57,284	36,102	39,234	45,958 + 0*/ 174,543 **(26,3%)**

No distribution happened during Q2, so all Q2 results are zero.

1.4 Communication Campaign to Support LLIN Distribution

As part of NMCP's Communication Committee, the HFA communication team has been working with NMCP and other partners, such as UNITEL, CICA/TKMI, among others, to promote harmonized communication activities aimed at generating sustainable results.

The post-distribution communication workplan is based on NMCP's objectives: aiming to promote community ownership of and commitment to malaria prevention by creating a culture of sleeping under LLINs consistently. The workplan includes the following activities:

- Training of provincial malaria supervisors and health promotion officers from the provinces covered by LLIN distribution campaign;
- Training of traditional authorities, namely, "*Regedores/Sobas grandes";*
- Placement of radio spots to promote the use of mosquito nets;
- Posters with messages about the use of mosquito nets.

The first group of activities was implemented in the five provinces covered during phase 1: Uige, Zaire, Malanje, Cuanza Norte, and Cuanza Sul, and happened during Q1 of FY17.

1.4.1 Communication Achievements During Q2:

The communication activities implemented during Q2 involved 2 provinces covered during phase 2 of the LLIN distribution campaign: Cunene and Namibe. The table below summarizes the results achieved during the communication activities in those two provinces:

Indicators	Q2 Target	Achieved	%
# DPS officers (SBCC & SPPM) trained in BCC techniques	**4**	**21**	**525%***
# of traditional leaders trained	**100**	**101**	**101%**
# of Supervisors of ADECOS trained	**28**	**32**	**114%**
# of TKMI/CICA volunteers trained as Supervisors	**5**	**7**	**140%**
# of TKMI/CICA volunteers as activists	**200**	**200**	**100%**

**Not only were DPS officers included, but also municipal directors of health (Directores Municipais de Saúde-DMS) under request from DPS, thus considerably increasing the number of officers trained on BCC techniques.*

The difference in the target number of Supervisors of ADECOS trained and achieved lies in the fact that another 4 supervisors joined this training: 2 from Kwanza Sul, 1 from Bengo and 1 from Moxico. These 4 supervisors were in the group that had already been trained by FAS and IFAL during the same period. HFA decided to include them in the training to avoid any kind of conflict.

Regarding the difference between the target number of TKMI/CICA volunteers trained and achieved resulted from the fact that both the TKMI/CICA Coordinator, as well as the J.C. Flowers Foundation Consultant attended the training.

1.4.2 Communication Activities Planned for Q3:

The following communication activities are being prepared for implementation during the next reporting period:

- National multi-channel SBCC campaign about awareness of malaria: symptoms, need to seek testing, treatment within 24 hours, and prevention by using bed-nets (LLIN). The several channels used are mainly through community leaders, radio, IEC materials, and SMS;
- Development of a National SBCC Campaign for MIP;
- Post-campaign communication activities in all LLIN-covered provinces;
- Work with NMCP Communication Committee to develop a manual for traditional and religious leaders for the post-campaign communication;
- Refresher course for trainers-of-trainers (TOT) in Huambo;
- Training of activist trainers in Huambo;
- Training of activists from nine municipalities of Huambo.

1.5 Major Constraints Faced during Q2 FY18:

The major constraint faced by HFA regarding LLIN distribution in 2018 was the very long delay by the DNSP/NMCP to decide how to replace the LLINs needed for phase 3 of the Mass Distribution Campaign, since the previously agreed nets had been redirected to all DPS of the country earlier in the year by the MOH. HFA had to wait until negotiations between the MOH and funding partners were completed, and new sources defined.

Because of the delay in finding a replacement for the LLINs to cover phase 3, a rescheduling of distribution had to take place and three provinces were left out of the Distribution Campaign in 2018: Cabinda, Bie, and Bengo.

1.6 Recommendations for Remaining of FY18:

Some of the lessons learned during the previous phases of LLIN distribution are listed below, and should become guidelines for future campaigns:

- Field scoping visits prior to distribution should always be accompanied by NMCP. A good example of that was the excellent results achieved in Cunene with high level of engagement of local authorities after a member of the NMCP visited the province as part of the HFA team;

- Local institutions such as church groups, community/grassroot groups, traditional leaders (sobas), and ADECOS are invaluable partners that allow for more efficient use of resources during the distribution and for continuous communication on LLIN use after the campaign;
- In areas of difficult access, registration and communication activities should be combined to reduce time, minimize costs, and ensure greater coverage, especially in nomadic populations;
- Private sector engagement allows for optimization of resources and increased sustainability (e.g. partnership with UNITEL);
- Improve coordination of SBCC activities among Supervisor for Provincial Behavior Change Communication (SPBCC, in Portuguese: *Supervisor Provincial de Promoção de Saúde*), SPPM, OPMs, and OPPMs;
- Increase dissemination of IEC materials to health units and communities;
- HFA should work more closely with NMCP to define a clear communication plan for the distribution campaign, in coordination with other partners (e.g. ADECOS, UNITEL).

1.7 Proposed Targets for Q3-Q4:

Now that the distribution of LLINs has restarted and new sources of nets to cover the new phase 3 provinces (six rather than nine) have been established, HFA proposes to implement the following activities, setting new targets for the final two quarters of FY18:

- Distribution of **2,970,875** LLINs
- Population to be covered: **5,347,575** beneficiaries (**132,620** pregnant women + **1,036,360** children >5)
- **3,143** community health workers (CHWs) - 2,834 activists and 309 field supervisors- to be trained in communication, registration, and distribution, during Phase 3 LLIN distribution, in all the provinces.

Quarter	Province	Population in 2018	LLINs need	nº of households	nº of children under 5	nº of Pregnant Women
Q3	Huambo	2,309,829	1,283,238	502,137	447,645	57,284
	Cuando Cubango	854,258	474,588	185,708	165,555	21,186
	Moxico	601,454	334,141	130,751	116,562	14,916
TOTAL		3,765,541	2,091,967	818,596	729,762	93,386

Quarter	Province	Population in 2018	LLINs need	nº of households	nº of children under 5	nº of Pregnant Women
Q4	Lunda Norte	972,183	540,102	211,344	188,409	24,110
	Lunda Sul	609,851	338,806	132,576	118,189	15,124
TOTAL		1,582,034	878,908	343,920	306,598	39,234

The LLIN Distribution Toolkit, presently being developed by Tropical Health (TH), will be completed and submitted for approval by the MOH by the end of Q4:

- ✓ The first draft of the toolkit will be delivered by TH to HFA around June 12th (end of Q3);
- ✓ After being revised, HFA/PSI will send it back to TH for completion, based on comments received;
- ✓ When the final draft in English is received back from TH, it'll be submitted to PMI/USAID for review and approval;
- ✓ Once the final version in English is approved by PMI/USAID, it'll be translated to Portuguese and submitted to NMCP/DNSP for a final review and approval (by the end of Q4 in Sept/18).

By the end of Q4, the Social Behavior Change Communication (SBCC) campaign (pre- and post-campaign plan) will have been updated and implemented in coordination with NMCP and other communication partners (ADECOS and UNITEL). The following targets are being proposed:

Indicators	Q3 + Q4 Target
# DPS officers (SBCC & SPPM) trained on BCC techniques	20
# of traditional leaders trained	250
# of trainers of activists	143
# of supervisors of activists	309
# of activists	2,834
# of TKMI/CICA volunteers trained as Supervisors (included above)	14
# of TKMI/CICA volunteers as activists (included above)	260
# of people reached with Unitel messages (pre, during and post campaign)	800,000
Local Radio spot on LLIN usage once a day, 7 days a week, one month before and one month after the mass distribution campaign	180 times per province

1.8 Environmental Mitigation Monitoring Plan (FY18):

Results 1: LLIN Distribution - Achieved Results FY18					
	Q1	Q2 *	Q3	Q4	Total
# of households receiving messages on appropriate use of LLIN	**796,257**	**N/A**	-	-	**796,257**
# of activists trained on communicating correct LLIN use messages to the population	**931**	**N/A**	-	-	**931**

**** Note: no LLIN distribution took place in Q2***

Result 2: Malaria Services throughout Targeted Municipalities Improved

2.1 Background:

At the proposal stage, the HFA team suggested the municipalities below based on: a) municipalities with the biggest population density in each province; b) mapping of existing activities being implemented by NMCP partners between August and September 2016, to avoid duplications and to maximize the resources made available by USAID/PMI. Although HFA only implements activities in 24 municipalities out of 61 in the PMI provinces, it covers **78%** of its population.

PROVINCE	NAME OF MUNICIPALITY	% OF TOTAL POPULATION OF PROVINCE	# OF HEALTH UNITS
Kuanza Norte	Cazengo Cambambe Ambaca	**74%**	**57**
Lunda Note	Lucapa Cambulo Chitato Cuango	**78.6%**	**39**
Lunda Sul	Saurimo Cacolo	**88%**	**49**
Malanje	Malanje Cacuso Calendula Cambundi Luquembo Cangandala	**81%**	**84**
Uíge	Negage Maquela do Z. Sanza Pombo Quimbele Puri Uige	**68%**	**125**
Zaíre	Mbanza Congo Soyo Cuimba	**80.5%**	**53**
Total		**78%**	**407**

2.2 Targets for FY18:

In order to increase the quality of ToTs, NMCP/DNSP identified CENFFOR (*Centro de Formação de Formadores*), a training institution linked to the Ministry of Public Administration, Labour and Social Security (MAPTSS), and asked HFA to work with them to train and certify all malaria trainers prior to new Malaria Case Management trainings in the provinces. As the CENFFOR curriculum is too long (92 hours over 1 month), it was negotiated to split the training in 2 parts: first part for the first groups conducted in April and the second one in July.

A comparable situation happened during Q1 after initial supervision visits by DPS and HFA staff to health units and health care providers in 2 (Zaire and Uige) of the six PMI provinces identified that the supervision tool being used (*Guião de Supervisão*), originally developed by the NMCP a few years back to monitor a health unit and hospital, was too long and cumbersome. Therefore, HFA (PSI and Mentor) decided in mid-Feb 2018 to advocate with the NMCP to update the supervision tool.

The need to improve the supervision tool and to increase capacity in adult teaching skills affected the training and supervision plans. All trainings and most supervision visits were re-scheduled to happen in Q3 and Q4 according to the table below:

Performance Indicators	Baseline 2016	Target 2018	Quarter targets for FY18				Achieved in Q1 + Q2/ Year Target
			Q1	Q2	Q3	Q4	
1. Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds.	2,868	1,000	0	0	300	700	No trainings
2. Number of health workers trained in malaria diagnostics with rapid diagnostic tests (RDTs) with USG funds.	1,247	1,542	0	0	500	1,042	No trainings
3. Number of health workers trained in malaria laboratory diagnostics (microscopy) with USG funds.	Not split before	135	0	0	60	75	No trainings
4. Number of health workers trained in intermittent preventive treatment in pregnancy (IPTp) with USG funds.	1,689	407	0	0	187	220	No trainings
5. Number of health workers who received formative supervision on malaria diagnostic in the fiscal year.	-	320	90	30	50	150	134 / 320 (41.9%)
6. Number of health workers who received formative supervision in ACT use in the fiscal year.	-	320	90	30	50	150	134 / 320 (41.9%)

***Note:** The number of health workers that received formative supervision on diagnosis (from 123 to 134) and treatment (from 123 to 134) in Q2 has been adjusted according to new data that came from the field staff in Zaire and Uige.*

2.3 Major Achievements during Q2 FY18:

As explained in the previous section, most of the activities during Q2 were focused on **technical support to NMCP/DNSP** to:

i) Update and disaggregate the NMCP Supervision Guide into three levels: Municipal, Provincial and National;

ii) Design a unified Presence List (to be used by all HFA areas with the same information on trainings implemented and trainees that participated): developed so that all malaria trainings could be properly inserted in the training database;

iii) Update National, Provincial and Municipal Case Management Training and Supervision Plans (attached);

iv) Verify the data collected and summarize findings of the Assessment of Health Units in the 6 PMI provinces (all municipalities) – final Assessment Report to be submitted together with Q3 Report;

v) Train malaria case management TOT trainers on Adult Teaching Skills: 41 malaria TOT trainers trained on teaching skills (phase 1) – see attached CENFFOR Proposal and Phase 1 Report.

Note:

***** The TOTs were appointed by the NMCP, with support from HFA, mostly based on results achieved by the refresher course for National Malaria Trainers provided during Q4 FY17, and the results of the trainings provided by those TOTs in September 2017 – see Q4 FY17 for more details.

***** The 41 TOTs trained by CENFFOR were comprised of NMCP appointed Malaria Trainers from all levels (National, Provincial and Municipal) and backgrounds (physicians, nurses and lab technicians).

***** According to the methodology of appraisal used by CENFFOR, there is no pre and post-tests. An evaluation is made at the end of phase 2 of the training.

The second area of focus in Q2 was the **implementation of formative supervision**, which consists of monitoring and evaluation of knowledge and practices of HWs on:

- correct use of rapid diagnostic test (RDT)
- diagnosis and treatment of malaria with Artemisinin-based Combination Therapy (ACT), and
- appropriate administration of Intermittent Preventive Treatment in Pregnancy (IPTp) in antenatal clinics (ANC), according to the national guidelines from the NMCP/Angola.

A total of **49** HW that were trained during Q4 in FY17 on malaria diagnosis using RDT and on case management with ACT were supervised in this reporting period (Zaire and Uige). In addition, **26** HW also trained during Q4 FY17 on malaria prevention in pregnancy (MIP) were also supervised (Zaire and Uige).

Regarding the implementation of **iCCM (ADECOS)**, the situation during Q2 FY18 was as follows:

- A national Technical Working Group (TWG) already exists to oversee the iCCM activities. Current members include the Global Fund, principal recipient World Vison International, UNICEF, WHO, MOH, FAS, IFAL, HFA and USAID. The last meeting with all TWG members was held on the 3rd of April 2018.
- As iCCM activities in the WVI pilot provinces have been ongoing for over one year now, and the ADECOS are already working in their communities.
- An overall evaluation to be implemented by UNICEF in the 6 active provinces is about to start. The results of such evaluation will serve as guidance for the development and implementation of iCCM's activities in the next stages. When completed, this evaluation will be shared with all partners/stakeholders.
- In each of the HFA two provinces, two municipalities were selected for implementation of the ICCM strategy:
  - Lunda Sul: municipalities of Cacolo and Dala
  - Zaire: municipalities of Tomboco and Soyo
- For each of the 4 municipalities, 30 ADECOS and one Supervisor were recruited by FAS. All 4 Supervisors were trained by IFAL in Q1-FY18.
- In late March 2018, a party, comprised by representatives from PSI, USAID, National Department of Public Health (DNSP/MOH) and FAS, went to both provinces (Lunda Sul and Zaire) for a field visit. This field visit had as main purposes to understand a) the feasibility of providing M&E support, particularly around data collection platform, for potential integration into DHIS-2, b) quality assurance through proven supervision methods, and c) lead probable improvements through timely technical assistance from local/ international experts.
- The iCCM activities in Zaire and Lunda Sul are being implemented in close coordination with the iCCM technical working group and the Global Fund to prevent duplication and ineffective use of resources.
- By the end of Q2, FAS hired and trained 714 ADECOS, who are actively working in the communities. Another 1,353 ADECOS are to be hired until the end of 2018 to reach a coverage of 37% of the total territory – at this stage it is at 4%.

2.4 Major Constraints Faced during Q2 FY18:

- **Case management:** ***Inconsistent supply of ACTs and RDTs***

  During the assessment visits of Health Units (HU) in the six PMI provinces and supervision visits in Zaire and Uige, it was observed that in some of the municipalities the confirmatory diagnosis of malaria was not being done, allegedly for lack of RDTs. Therefore, in those HUs, most cases were being treated based on clinical symptoms only.

It was also noticed that the correct use of ACTs, in accordance with the National Protocol for Treatment of Simple and Severe Malaria, was not being appropriately followed. For some patients, for example, simple malaria cases being treated with severe malaria treatment regimens, also allegedly due to inconsistent supplies of ACTs at those HUs. Many simple cases were being treated with injectable artemether and oral quinine. The situation was discussed with DPS and NMCP, who confirmed the inconsistent supply of RDTs and ACTs in some provinces. A more detailed report on the findings of the assessment and supervision visits will be submitted together with Q3 Report.

Note: *Important to also note that all assessment and supervision visits were done jointly with DPS malaria officers and, sometimes, with NMCP members. Therefore, all information gathered during those visits was shared among the participants, who jointly completed the reports and submit them to DPS and NMCP.*

- **MIP:** ***Inconsistent supply of IPTp (SP) makes demand creation and adherence to ANC visits challenging***

  During supervision visits to ANC units, a common situation was observed in regard to the use of sulfadoxine/pyrimethamine (SP): frequent stockouts. Most HU informed visiting supervisors that ANC services have been prescribing SP (following the national protocol - attached) for purchase outside the health system (in private pharmacies), without assisted use (directly observed treatment - DOT). It's been reported that most ANC clients have not been taking the correct dosages of SP, either for lack of funds to purchase the drug, or for having forgotten to take the drugs when prescribed.

Note:

** Same comment as above - a more detailed report on the supervisions carried out in the 24 HU during Q2 will be submitted together with Q3 Report.*

** Important to also note that all supervisions are done jointly with DPS malaria officers and, sometimes, with NMCP members. Therefore, all information gathered during the supervisions is shared with the supervision participants, who jointly complete the supervision report and submit it to DPS and NMCP.*

- **iCCM: Owned by FAS/MAT but needs better integration of DNSP/NMCP/DPS**

  The Ministry of Territorial Administration (MAT), through FAS (*Fundo de Apoio Social*), and MOH, through NMCP, are both responsible for implementing and sustaining the ADECOS strategy in the country, with help from external funding partners, such as the Global Fund (GF) and USAID. The NMCP established in 2016 a Technical Working Group (TWG) to coordinate the implementation of the health component of the ADECOS (treatment of uncomplicated malaria cases among children under 5 years of age), and more recently confirmed interest in developing a full blown "Integrated Community Case Management (iCCM) with the ADECOS, with inclusion of diarrhea and pneumonia. The iCCM TWG has among its members, representatives of the GF, PMI, PSI/HFA, UNICEF, WHO, World Vision (WV), and others.

  Nevertheless, it has been observed, since the inception of HFA in Feb 2017, that in most meetings of the iCCM TWG, no representatives from FAS or WV have been attending, causing a disconnect between field implementers and central level coordination. The opposite has been observed in most provinces where the ADECOS are operational: FAS and WV have been meeting without the participation of DPS representatives.

  Since FY17, HFA has been advocating with NMCP/ DPS and FAS/WV, with some success, for both groups to better engage in the coordination of such important strategy to combat the highest killers of children >5 in Angola: malaria, diarrhea and pneumonia.

  During Q2 FY18, the DNSP/MOH formalized the appointment of an iCCM Focal Point, Dr. Marques Gomes, from the NMCP. Dr. Gomes immediately promoted a few joint meetings with FAS and WV to strengthen the partnership and improve the effectiveness of the ADECOS in provinces covered by WV/GF and HFA/USAID.

- **Other issues identified as constraints in the implementation of iCCM**

  - Health training of ADECOS is conducted by ADECOS supervisors/TOT, most of them without health training, which could compromise quality of training in iCCM;
  - Information gathered by ADECOS is transmitted to the Technical Units of the Municipal Administration and are stored in **SIBM** (***Sistema de Informação Básica Municipal***);

- All stored data is not regularly shared with the Municipal Health Directory (DMS) and neither with the Provincial Health Directory (DPS), thus not reaching NMCP/MOH, leading to under reporting of simple malaria cases being treated at community level by ADECOS;
- Coverage of ADECOS is too low: only two communities (microareas) in each of the two municipalities in provinces where ADECOS have been operating are covered, representing between 4% and 30% of the total geographic area, depending on the size of each province. Low coverage can negatively affect the impact of the ADECOS strategy on the reduction of malaria in those provinces.

2.5 Recommendations for Remaining of FY18:

- **PMI to advocate with MOH to better coordinate implementation and expansion of iCCM strategy**
  - ***Share ADECOS reporting with DPS***: identify ways to tap into the information gathered in the SIBM platform by the Technical Units that receive data from ADECOS, either by developing links with DHIS2, or defining other ways of sharing the information directly with DMS and DPS, such as reviewing and updating data collection forms to include the indicators of malaria cases managed by ADECOS. The Municipal Focal Point could collect and send the data to DPS on a monthly basis, and the Provincial Malaria Supervisor could consolidate and send the data to NMCP also on a monthly basis. DHIS2 has already been presented to the FAS team responsible for the ADECOS, with a very good response. Meetings with FAS, World Vision, NMCP, and GEPE/ GTI are being planned for Q3 to analyze the possibility of linking SIBM and DHIS2, and to ensure the harmonization of ADECOS activities among different partners.
- **NMCP to ensure procurement and regular supply of:**
  - ACT, RDT and SP supply to improve Case Management, MIP and ANC adherence
  - Rectal artesunate suppository (RAS) for severe malaria treatment in children, when transferring to referral units. Health workers receive training on the use of RAS (not practical) as part of the malaria case management training being provided (copies of Training Manuals already submitted to PMI).
- **Continuation of training, supporting formative supervision** of service providers, especially for the HUs with improved supervision reports. MOH is sending recently graduated service providers with a low level of knowledge/capacity to the provinces.
- **Quarterly coordination & evaluation meetings** on implementation of malaria activities at provincial level: NMCP and HFA would regularly hold meetings (every month in a different PMI province) with OPMs, SPPMs, OPPMs, Heads of Departments of Public Health, and the central level coordination team. The main objective of such meetings would be to coordinate and evaluate the implementation of all malaria activities being developed in each province, having in mind the General Plan of Training and Supervision Plan for that province, new opportunities, and needs to improve quality of malaria services. OPMs would support the Provincial Malaria Team to present the epidemiological situation, achievements during the last quarter, and plans for the following period.
- **Support NMCP to organize a national meeting** to review national guidelines based on updated WHO recommendations for malaria case management, MIP, and Lab diagnostic.

2.6 Proposed Targets for Q3 – Q4:

In the next two quarters (Q3 and Q4), HFA will focus on the main activities of this component: ***trainings*** and ***formative supervision***:

- **Strengthen the technical capacity of malaria service providers** at provincial and municipal level to appropriately diagnose and treat malaria (including MIP):

HFA Result 2 – Training Targets for Q3-Q4 FY18			
Province	**# of existing health facilities (HF)**	**# of HW targeted for training**	**# of lab technicians targeted for training**
Malanje	84	318	28
Lunda Norte	39	148	13
Lunda Sul	49	186	16
Cuanza Norte	57	216	19
Zaire	53	201	18
Uige	125	473	41
TOTAL	**407**	**1,542**	**135**

- **Provide formative supervision to HU and service providers** in all target municipalities of PMI provinces:

HFA Result 2 – Formative Supervision Targets for Q3-Q4 FY18			
Province	**# of existing health facilities (HF)**	**# of HW trained in Malaria Case Management (ACT and RDT) to be supervised**	**# of Lab Technicians trained in lab diagnosis (microscopy) to be supervised**
Malanje	84	66	66
Lunda Norte	39	31	31
Lunda Sul	49	38	38
Cuanza Norte	57	45	45
Zaire	53	42	42
Uige	125	98	98
TOTAL	**407**	**320**	**320**

Since the basic conditions for implementing trainings and formative supervisions have been created, through training TOTs in adult learning skills (CENFFOR) and updating and segregating supervision tools, the key activities to be implemented in the next quarters (Q3-Q4) will be to:

- Provide the second phase of training on adult teaching skills to malaria TOTs (through CENFFOR);
- Implement the updated training and supervision plans (attached) for Q3 and Q4;
- Reinforce the training of OPMs, OPPMs, SPPMs and TOTs in management and use of database (e.g. insert data on trainings and supervisions in database);
- Train and supervise ADECOS in Lunda Sul, and Zaire;
- Train supervisors of ADECOS in the use of supervision tools and data collection app;
- Implement simple malaria case management of children under 5 years of age by ADECOS;
- Promote regular supervision visits (HFA, DPS and NMCP) to verify the work of ADECOS;
- Supervise data collected by ADECOS and registries of patients assisted (simple malaria cases) and patients referred (severe malaria cases) to HU;
- Train HWs from the health facilities located near the micro-areas of ADECOS (reference points) on malaria case management.

QUARTER 3 FY18	April				May				June			
Key Activities	**W 1**	**W 2**	**W 3**	**W 4**	**W 1**	**W 2**	**W 3**	**W 4**	**W 1**	**W 2**	**W 3**	**W 4**
Training on adult teaching methodology for Malaria TOTs (CENFFOR)		X	X									
Formative supervision on ACT/RDT; Microscopy, IPTp	X	X	X	X	X	X	X	X	X	X	X	X
Training of HW on case management ACT/RDT						X	X	X	X	X	X	X
Training of Lab Tech on Lab diagnosis by microscopy						X	X			X	X	
Training of HW on Malaria in pregnancy /RDT						X	X	X	X	X	X	X
Management and use of database for: trainings, supervisions and epidemiology	X	X	X	X	X	X	X	X	X	X	X	X
iCCM activities												
Training of ADECOS in Lunda Sul and Zaire			X	X								
Training of supervisors in the use of supervision tools (tablets)							X	X				
Implementation of mild malaria case management of children under 5 years of age by ADECOS												
Supervision of ADECOS in their micro-areas on data collected and registries of patients assisted, and patients referred to Health Units							X	X	X	X	X	X
Training on malaria case management of health workers from the Health Facilities located near the microareas of ADECOS (reference points)						X	X					

2.7 Environmental Mitigation Monitoring Plan (FY18):

Results 2: Malaria Case Management (6 provinces; 24 municipalities)					
	Achieved Results				
	Q1	**Q2**	**Q3**	**Q4**	**Total**
# of facilities in compliance with waste management standard	**N/A**	*****			**0**
# of TOTs trained on lab waste management	**N/A**	**N/A**			**0**
# of health workers trained in waste management	**N/A**	**N/A**			**0**
# of ADECOS trained in waste management	**N/A****	**N/A****			**0**

** In Q2 HFA initiated conversations with MOH-NMCP to see if there is an existing instrument to assess facilities. The MOH does not have any instrument, so HFA developed 1 instrument based on USAID, 2015 Sector Environmental Guidelines for Health Care Waste. The assessment will take place in Q4;*
*** the ADECOS component of HFA has not yet started*

Activities already implemented:

- Workshop held at INSP with NMCP and PSI on February 16th, 2018 on "environmental mitigation and monitoring of the impact of hospital waste management at health unit level". The workshop was a result of the previous meeting on February 12th, and took place with the same technical staff, with the objective of discussing and developing a presentation for refresher trainings of HWs from distinct levels: from medium level nurses and lab technicians to medical doctors, certified nurses and biochemists, including staff responsible for hospital garbage disposal.
- As the results of the workshop: a training presentation on the "impact of hospital waste management at health unit level" was developed as planned and will be tested and later submitted for approval by the health authorities responsible for the area.
- A protocol for routine disposal of solid residues at health units will be developed in the coming quarter (Q3), together with monitoring and supervision cards (checklist).

Result 3: Sustainable Model for Providing High-Quality HIV/AIDS Services Established

3.1 Background:

Management Sciences for Health (MSH) is part of the HFA consortium with responsibilities for establishing a sustainable model for providing high-quality HIV/AIDS services. The following report refers to R3: HIV/AIDS.

3.2 Summary of Major Achievements:

During the second quarter of the HFA Project's FY18, MSH reinforced collaboration with key stakeholders, including the National Institute to Fight HIV/AIDS in Angola (INLS), the Cabinet of the Provincial Health Directory of Luanda (GPSL), the National Program of TB Control (PNCT), the African Field Epidemiology Network (AFENET), the National Institute of Public Health (INSP), and the USAID-funded Procurement Supply Management Project (PSM).

MSH has identified key elements for the HIV response through seven HFs that require strengthening to achieve the objectives of the continuum of care model (COC) to all people living with HIV (PLHIV). These elements include a review of recent service quality assessments, supervision findings, and program data, and permanent supervision of key informant interviews with patients conducted by Patient Assistant Facilitators (PAFs), Community Counselors (CCs), facility management teams, Case Managers (CMs), and other stakeholders that are familiar with these current services. Based on these systemization daily experiences, HFA focused on strengthening TB/HIV co-infection management and viral load testing services.

At the HF level, HFA completed the following activities during Q2:

- Continued improving the collection and analysis of data across the seven HFs through weekly supervision;
- Used data to identify missed opportunities (Ex. direct relatives of patients with TB and / or HIV + who accompany to the consultation, children with moderate/severe malnutrition, etc.) for HIV Testing Services (HTS) within each HF. Consequently, HFA conducted closer follow up through the PAFs with all visitors within the different services of the HFs. HFA (through PAF perform personal accompaniment) also reduced the waiting period between getting the test, receiving results, and counseling, sometimes more than 1 hour;
- Improved the control of stock management at the facility level and strengthened collaboration with the supply chain (PSM/MSH) through permanent supervision and reporting (report should include concise but comprehensive information);
- Improved the transition of pre-antiretroviral treatment (ART) patients to ART;
- Improved patient retention and adherence to treatment through PAFs' support;
- Installed GeneXpert equipment donated by Linkages (USAID) in three HFs: Kilamba Kiaxi, Viana, and Esperança;
- Furnished all seven HFs with the equipment needed to improve TB/HIV services and start viral load testing in Q3 (i.e. 4 refrigerators, 5 centrifuges, furniture, and 2,000 TB cartridges.);
- Supported supervision and quality control of data in HIV services;
- Ensured adherence to norms and protocols for quality improvement developed by MINSA, and INLS, through the CMs and PAFs doing Quality Improvement activities, and
- Provided technical assistance and training to carry out quality improvement activities (Follow the Protocol and fluxogram from the INLS and MoH) in the HFs, through daily supervision.

All activities implemented at the HF level were planned and implemented in close coordination with the Laboratory of Molecular Biology-INLS (LBM), AFENET, PNCT, INSP and PSM to ensure broad buy-in, support, and sustainability.

Figure 1: Results and Targets for FY18/Q2 across the Clinical Cascade

Q2/FY18 Achievement of Results against Target across the Clinical Cascade

INDICATORS	ANNUAL TARGET 2018	TARGET Q2 [1]	RESULTS Q2 [1]	RESULTS against TARGET Q2
1 HTS_TST	43,845	10,962	17,732	161.8%
2 HTS_TST_POS	5,843	1,461	1,529	104.7%
3 TX_NEW	7,543	1,886	982	52.1%
4 TX_CURR	22,003	22,003	20,014	90.9%
5 TB_STAT [1]	85.5 % (4,005 / 4,682)	85.5 % (2,003 / 2,341)	88.6% (3,009 / 3,394)	103.6% (150.2% / 144.9%)
6 TB_ART [1]	89.7 % (673 / 750)	89.8 % (337 / 375)	55.0% (241 / 438)	61.2% (71.5% / 116.8%)
7 TB_PREV [1]	68.9 % (1,954 / 2,836)	68.9 % (977 / 1,418)	50.4% (711 / 1,410)	73.1% (72.7% / 99.4%)
8 TX_TB [1]	4.9 % (918 / 18,615)	2.5 % (459 / 18,615)	3.1% (228 / 7,225)	124.0% (49.6% / 38.8%)

Note 1: TB indicators are biannual consequently Target and Results are Q1 + Q2.

Figure 2. Results of Q1 and Q2 (FY18) compare with the Annual Target

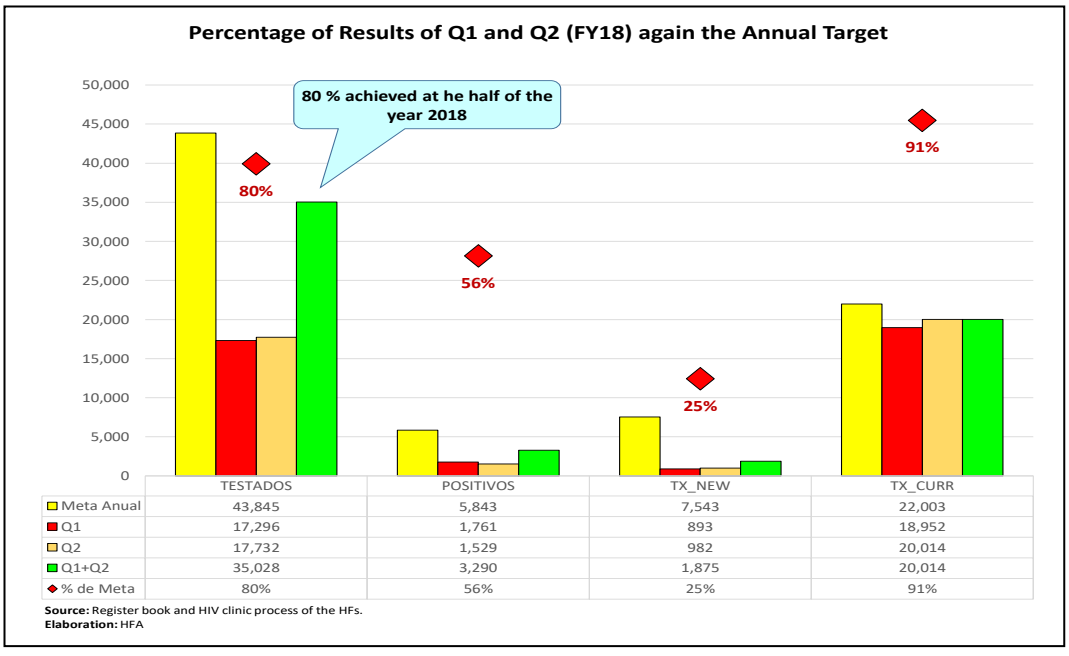


Figure 3. Number of People Tested and Percent of Positives Identified by Month and HF during Q2

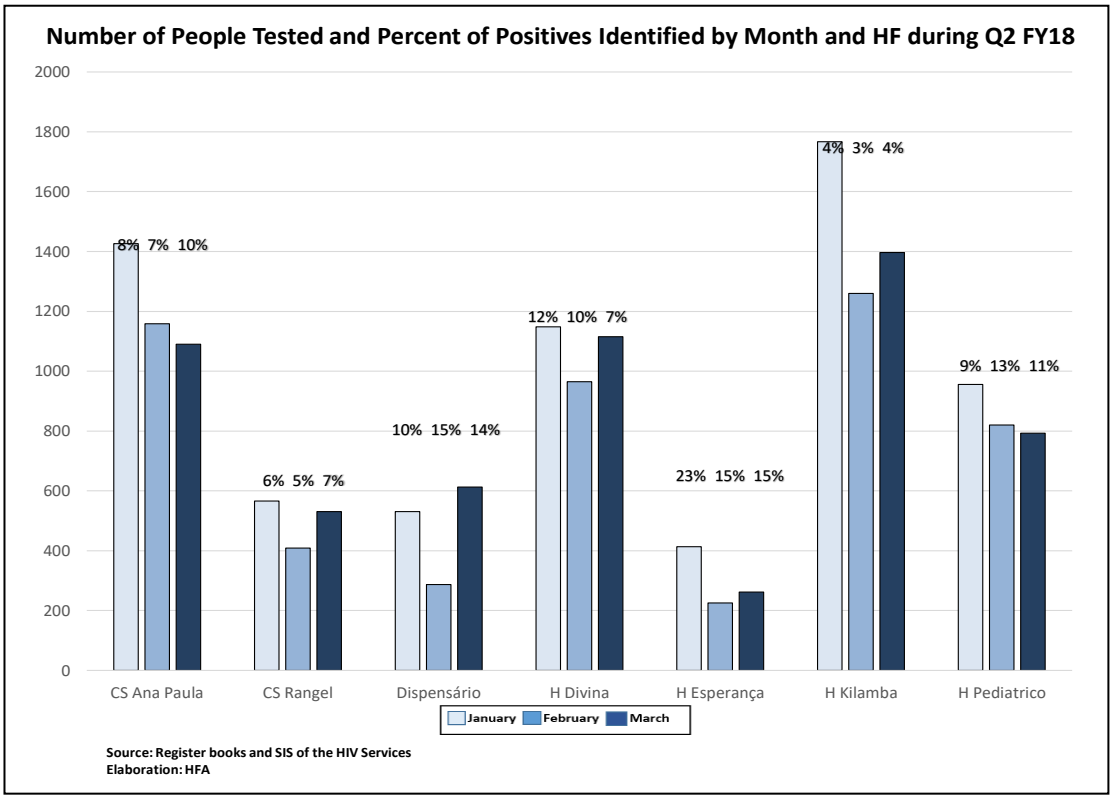
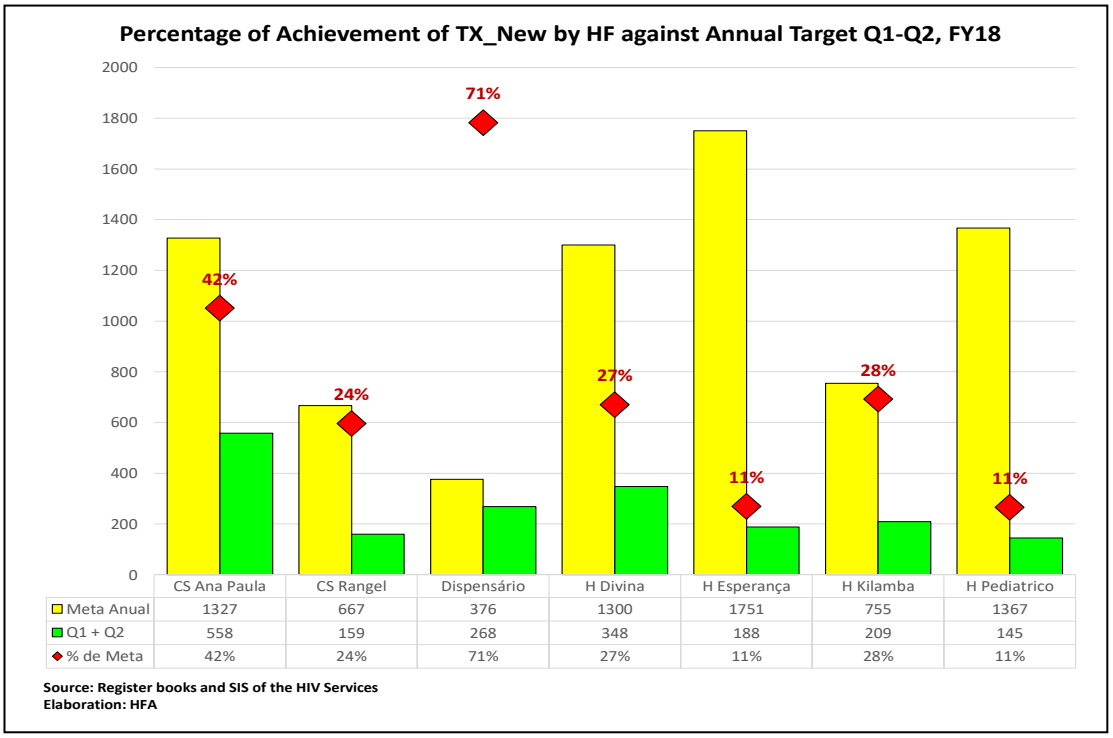
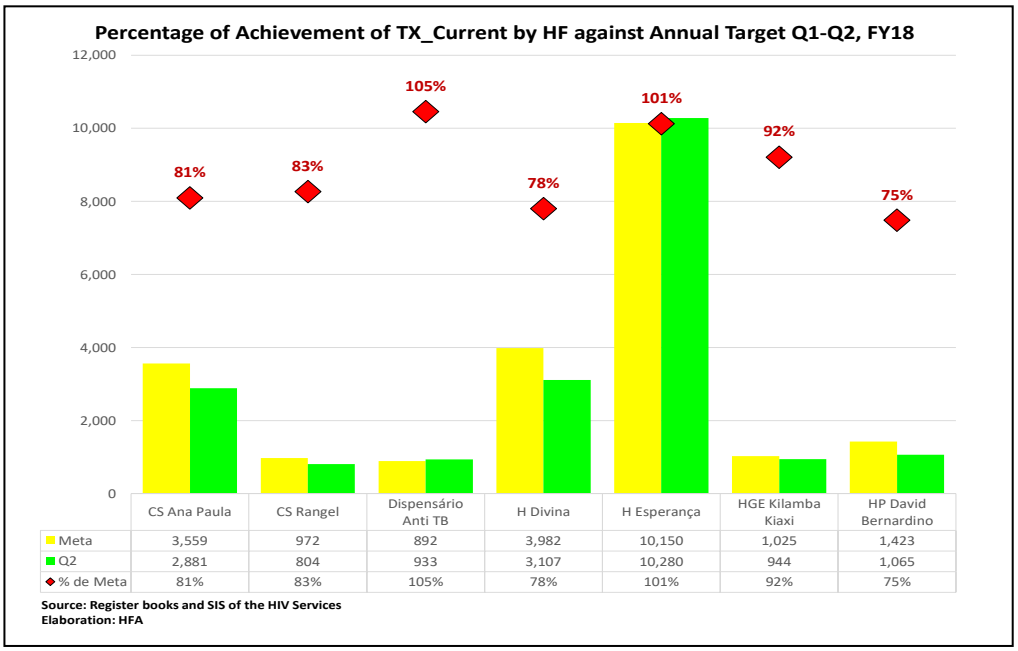


Figure 4. Percentage of Achievement of TX_New by HF against Annual Target Q1-Q2, FY18



	CS Ana Paula	CS Rangel	Dispensário	H Divina	H Esperança	H Kilamba	H Pediatrico
Meta Anual	1327	667	376	1300	1751	755	1367
Q1 + Q2	558	159	268	348	188	209	145
% de Meta	42%	24%	71%	27%	11%	28%	11%

Figure 5. Percentage of Achievement of TX_Current by HF against Annual Target Q1-Q2, FY18



	CS Ana Paula	CS Rangel	Dispensário Anti TB	H Divina	H Esperança	HGE Kilamba Kiaxi	HP David Bernardino
Meta	3,559	972	892	3,982	10,150	1,025	1,423
Q2	2,881	804	933	3,107	10,280	944	1,065
% de Meta	81%	83%	105%	78%	101%	92%	75%

3.2.1 Brief Narrative on Results by Indicator

1. **HTS_TST:** During Q2 FY18, the project reached 17,732 individuals with HTS. This achievement represents 161.8% of the target for Q2 (10,962) and largely reflects the success of the project's key testing strategies, including:
    a. Permanent quality control of the Testing Points in each HF;
    b. Provision of collective and individual counseling through the PAFs;
    c. Deployment of the Index Case Tracing and Testing (ICTT) strategy; and
    d. Supportive supervision to guarantee improvements in the quality of the implementation of the testing activities and on data capture in the health register.

2. **HTS_TST_POS:** During Q2 FY18, 1,529 new positive cases were identified through the project. This achievement represents 104.7% of the target for Q2 (1,461). Together, Q1 and Q2 achieved 56% of the Annual Target (FY18) of positive cases (Figure 2). Contribute to this achievement the Index Case Testing and Tracing strategy, which produced a high yield (around 30%); and the focus of the PAFs, CCs, and CMs on testing and screening high-risk people in personal report on behavior.

3. **TX_NEW:** During Q2 FY18, there were 982 new registered cases on ART. This achievement represents 52.1% of the Q2 target of 1,882 cases. During Q1, there were only 893 new registered cases (Figure 2). The increase in Q2 was due to the completion of the Test & Treat Strategy (T&T) in the seven HFs. However, progress against the annual target for FY18 is still suboptimal given the overall 25% achievement against the target of 7,543 (Figure 2). The T&T strategy was finalized just at the end of Q2, therefore HFA has planned to reinforce the strategy and support the HFs in supervising all testing points in order to ensure linkage during first consult to initiate ART immediately through the CMs and PAFs. Achievement against annual target FY18 by health facility is shown in Figure 4.

4. **TX_CURR:** There were 20,014 patients on treatment during Q2, representing 90.9% of the Annual Target FY18 (22,003). Achievement against target by health facility can be seen in Figure 5.

5. **TB_STAT:** The total number of patients with TB who know the HIV+ serologic state achieved during the first semester is 3,009 (numerator) and the target was 2,003 patients. The total number of new cases of TB in this semester is 3,394 (denominator) and the target was 3,009. At the end of the first semester, the results of this indicator against target is 103.6 %.

6. **TB_ART:** The total number of TB patients who initiated ART in the first semester is 241 and the target was 337 patients. The total number of TB patients found to be HIV+ during this semester is 438 and the target was 375. At the end of the first semester, the results of this indicator against target is 61%. Because the co-infected patients have to start first with TB treatment, and due to the frequent lack of TB drugs, some patients could not start ART.
7. **TB_PREV:** The total number of patients who initiated preventive treatment with Isoniazid during the first semester was 1,410 (target was 1,418) and the total number of patients who finalized prevention treatment was 711 (target was 977). Achievement against target for this indicator is of 73%. The key challenge problem here has been the lack of proper documentation in the register at the time of being given the preventive treatment, and sometimes the lack of Isoniazid. The only method to analyze this indicator is the revision of each clinic process, and sometimes it is not registered the end of prevention treatment. HFA started already the supervision of this register by the PAF.
8. **TX_TB:** The total number of patients who passed the triage for TB was 7,225 (target was 18,615) and the total number of patients who started TB treatment was 228 (target was 459). Based on project targets for this semester, HFA achieved 3.1% - exceeding the Q2 target by 2.5%.

3.3 Summary of Key Interventions:

3.3.1 Training and Supervision

Per PEPFAR guidance, the revision and development of standard operation procedures (SOPs) to improve standards for HIV care and treatment services is the responsibility of ICAP. HFA must adjust the national guidelines to fit under HFA's facilities. The number of facility staff trained during Q2 by HFA on HIV/AIDS services in the seven HFs was 195. This number is the total staff planned for the Q2 to be trained into the seven HFs. Trainings were conducted on the following topics:

• Test and Treat strategy (INLS)	• GeneXpert MTB/RIF
• GeneXpert service training (HFA/PNCT/INSP)	• The use of the Risk Evaluation form

The Senior HIV Adviser and the Coordinator of PAFs and CCs supervised all the staff providing HIV Services. The supervision included weekly visit to each HF during the morning working time:

• Supervision/mentoring for nurses at HIV testing points	• Supervision/mentoring for technicians (HIV focal points and clinicians) responsible for care of co-infected patients
• Supervision/mentoring for technicians (HIV focal points and clinicians) working in HIV services	• Supervision of the active search conducted by PAFs of the patients who lost to follow up
• Supervision of the Index Case Testing and Tracing strategy implementation conducted by the Case Managers and the Responsible Coordinator of these activities	

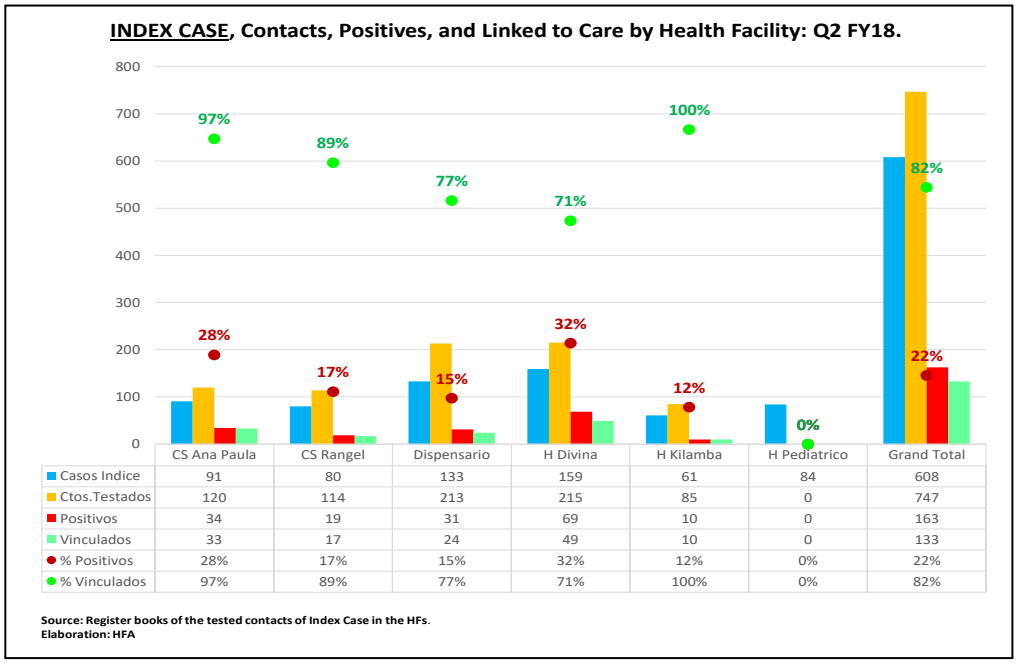
Figure 6. IR 3: Sustainable Model Providing High-Quality HIV/AIDS Services: Q1-Q2 FY18 *(also EMMP indicators FY18).*

IR 3: Sustainable Model Providing High-Quality HIV/AIDS Services Q1-Q2 FY18		
Indicators	**Achieved**	
	Q1	**Q2**
1. Number of SOPs revised/developed to improve standards for HIV care and treatment in nine PEPFAR facilities	Responsibility of ICAP	Responsibility of ICAP
2. Number of staff trained by HFA on the use of SOPs for HIV/AIDS services in the 7 HFs	70	195
3. Number of trained staff supervised by HFA on the use of SOPs for HIV/AIDS services	37	48

3.3.2 Index Case Testing & Tracing

During the reporting period, HFA completed the implementation of ICTT in six HFs (all except for Esperança), and the strategy continues to be very successful due to the excellent work done by HFA's Community Counsellors and strong coordination with health facility staff, including PAFs and CMs supported by HFA.

Figure 7. Index Case, Contacts, Positives, and Linked to Care by Health Facility: Q2 FY18

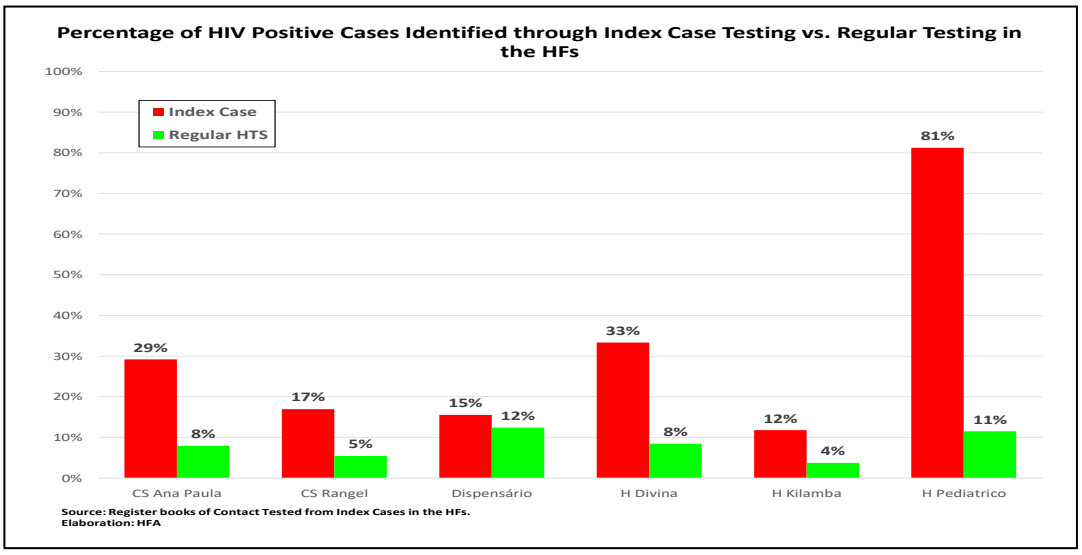


	CS Ana Paula	CS Rangel	Dispensario	H Divina	H Kilamba	H Pediatrico	Grand Total
Casos Indice	91	80	133	159	61	84	608
Ctos.Testados	120	114	213	215	85	0	747
Positivos	34	19	31	69	10	0	163
Vinculados	33	17	24	49	10	0	133
% Positivos	28%	17%	15%	32%	12%	0%	22%
% Vinculados	97%	89%	77%	71%	100%	0%	82%

Source: Register books of the tested contacts of Index Case in the HFs.
Elaboration: HFA

Figure 7 presents the number of index cases (blue) and contacts tested (yellow), as well as the percentage of positive cases (red) identified among contacts by facility. The most important point is the high percent of positives (red dots) with an average of 22% and the high percentage of positives linked to treatment (green dots) with the average of 82%.

Figure 8. Percentage of HIV+ Cases Identified through Index Case Testing vs. Regular Testing in the HFs



Source: Register books of Contact Tested from Index Cases in the HFs.
Elaboration: HFA

Figure 8 shows that yield through testing modalities (green bar) in health facilities is around 10%, while through ICTT (red bar) it is around 30%.

Figure 9: Index Case, Positives and Linked to Treatment by Age Group

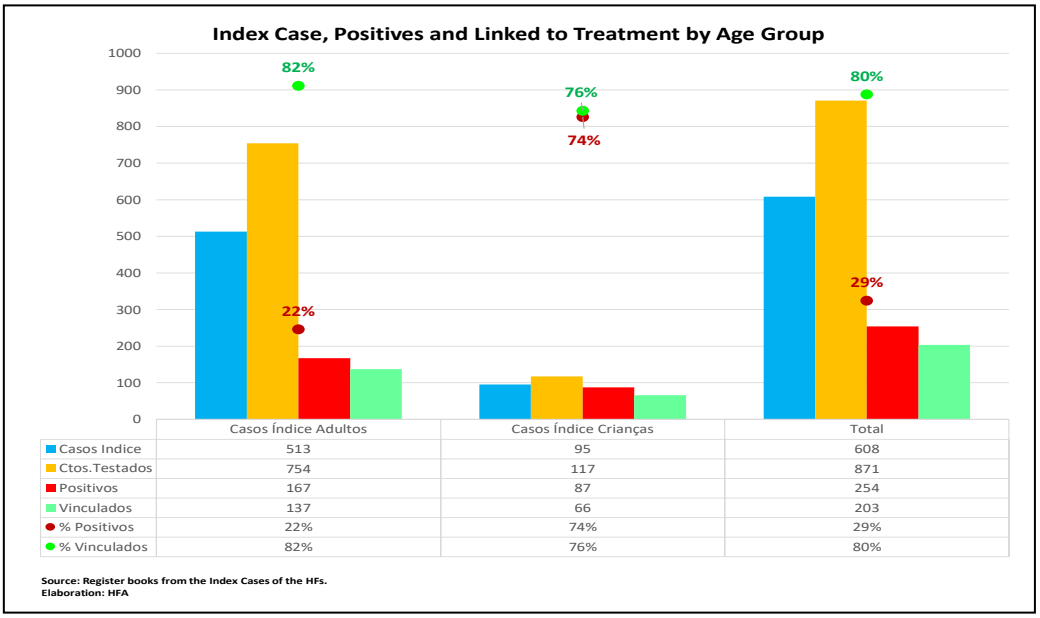


Figure 9 shows the positives cases identified and linked to treatment by age group: Adults >15 years and Children <15 years old.

3.4 Major Constraints and Solutions:

- **Viral Load (VL) Suppression:** One of the main constraints during Q2 was the implementation of VL testing (Figure 11). The collection of samples continued in the HFs that were part of the pilot project implemented by ICAP during FY17 (Esperança, Divina, and Pediátrico). The lack of equipment needed to administer VL services was a key constraint in the rest of the HFs (Viana, Rangel, Kilamba Kiaxi, and Dispensario). The solutions identified to address these constraints included:
    - ✓ HFA completed laboratory equipment installation and provided the basic supplies to initiate VL activities in the remaining four HFs (Viana, Kilamba Kiaxi, Rangel, and Dispensario);
    - ✓ HFA, together with LBM (INLS) and AFENET, conducted a training on VL in Viana. HFA will conduct the same training in three other HFs (Kilamba Kiaxi, Rangel, and Dispensario) during Q3, in April 2018;
    - ✓ The project reinforced collaboration with GPSL to plan for the provision of basic supplies for the HF laboratories;
    - ✓ To combat patient absenteeism, the project implemented the VL requisition form and sample collection at the same day of the consultation (patients who meet the conditions required to perform VL). It's a pilot test to analyze the results in Viana Health Facility; and
    - ✓ HFA provided 2 days per week in each HF supervision through CMs and PAFs to interpret results of VL testing, target active search, and follow up with patients who are not virally suppressed.

Figure 10. Viral Load Suppression in the Seven HFs

VIRAL LOAD

Facility	FY18 Target	Resultados Registrados Out 2017 to Mar 2018	Percentual Alcançado	Percentual Supressão	Estimativa pacientes Com CV at Set 2018
Rangel	479	0	---	---	747
Viana	1,635	39	2 %	---	2,864
Dispensario	437	0	---	---	943
Divina	1,973	1,075	54 %	88 %	3,066
Esperanca	5,947	4,730	80 %	70 %	10,074
Kilamba Kiaxi	495	0	---	---	866
Pediatrico	547	343	63 %	29 %	1,090

AFENET - Data collected by Facility Lab VL Log book
In the 7 HFA HFs approximately need around 20,000 VL Tests until September 30th.2018

- **ART Adherence and Retention:** Ensuring patient adherence to ART and retention was another challenge. HFA implemented the following activities to accelerate progress and identify patients who are lost to follow up:
  - ✓ Implemented active search by the PAFs on the same day patients miss their appointments;
  - ✓ Ensured active search by the PAFs in coordination with HIV focal points to identify self-transfer patients and deaths;
  - ✓ Coordinated with and provided information to the social sector to help and support HIV patients; and
  - ✓ Collaborated with the Provincial Directory of Information, Education and Communication (DPIEC) of the INLS to improve implementation of the national guidelines on adherence and retention.
- **Shift of Hospital Esperança to a National Referral Hospital (School and Specialized Hospital in HIV/AIDS for complicated cases:** Angola's MOH mandated that Hospital Esperança would become an academic institution and serve as a National Referral Hospital. HIV testing will be offered only as a routine service and ICTT will be suspended. INLS has to take the final decision to select, with HFA support, another HF to replace it. HFA is preparing a proposal to INLS and USAID/PEPFAR for it.

3.5 Proposed Activities for Quarter 3 (April to June 2018):

Activities	April				May				June			
	1w	2w	3w	4w	1w	2w	3w	4w	1w	2w	3w	4w
Training on VL in Viana	x											
Training on VL in Dispensario		x										
Training on VL in Rangel			x									
Training on VL in Kilamba Kiaxi			x									
Training on the use of GeneXpert by Hospitec/Cepheid-AFENET in Viana, Rangel, Esperanca and Kilamba Kiaxi				x	x							
Training for requesting GeneXpert MTB/RIF – in the 7 HFs supported by HFA						x	x					
Training in reinforced adhesion (PAFs, CCs and Civil Society									x			
Training in reinforced adhesion for professional staff (CMs, Doctors, Nurses and Psychologies)											x	
Formation in Diagnosis & Clinic follow-up of Children living with HIV (Hosp. Pediatrico)										x		
Formation on Informatics System(M&E Technicians, PAFs & Data collectors of the 7 HFs supported by HFA)							x	x	x			
Consolidation of the strategy in the HIV/TB Co-infected Services in Dispensario, Divina Providencia and Hosp. Pediatrico					x							
Integration of the 3 remaining HFs supported by HFA into the National System of VL (Rangel, Kilamba Kiaxi and Dispensário)						x	x	x				
Transference of the responsibility of M&E on HIV from PSI to MSH within the HFA					x							
Integrated supervision among INLS, PNCT, INSP, GPSL and HFA into the 7 HFs (HFA)			x	x			x	x			x	x
Support in the Institutionalization of the Circular with recommendations on TB and use of GeneXpert in the 7 HFs supported by the HFA					x	x						

3.6 Environmental Mitigation Monitoring Plan FY18:

IR 3: Sustainable Model Providing High-Quality HIV/AIDS Services Q1-Q2 FY18		
Indicators	**Achieved**	
	Q1	**Q2**
1. Number of SOPs revised/developed to improve standards for HIV care and treatment in nine PEPFAR facilities	Responsibility of ICAP	Responsibility of ICAP
2. Number of facility level staff trained by HFA on the use of SOPs for HIV/AIDS services *	70	195
3. Number of trained staff supervised by HFA on the use of SOPs for HIV/AIDS services *	37	48

**All the staff who participate in the training and supervision receive information (theory and practical) in order to any activity not affects the environment, mainly on the disposal of medical and laboratory materials.*

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

4.1 Background

In the second year of implementation of the Family Planning component of HFA, the Government of Angola continues to receive support to conduct training for healthcare providers, supervise public health units, update and publish protocols and create an enabling environment for family planning.

During the first quarter of FY18, several changes were made to the workplan, especially regarding SBCC activities and reporting forms to include data aggregated by gender and age groups. For instance, the number of adolescent reached (both female and male aged 15 to 19 years) is currently reported in a separated line than adults in reproductive health (aged 20-49). In addition, considerations taken from gender integration training were also incorporated into SBCC activities and trainings as advised by USAID's Gender Advisor. For instance, instead of training female healthcare providers only, male healthcare providers were trained to shift gendered community perspectives towards family planning.

4.2 Targets for FY18:

In Quarter two, a special attention was given to the following points:

- Increase supportive supervision at all USG-assisted service delivery points (SDPs) offering FP/RH counseling or services;
- Support the Department of Health Promotion in printing and dissemination of the National FP/RH Communication Strategy once finalized; and
- Provide refresher trainings to FP healthcare providers by municipality in both provinces (Luanda and Huambo).

The last column of the table below shows the targets achieved in Q1 + Q2 towards the year performance indicators:

Performance Indicators	FY16 Baseline (PSI Survey/ DHS/ SASH)	Targets for 2018	Quarter targets for FY18				Achieved in Q1+Q2/Year Target
			Q1	Q2	Q3	Q4	
1. Percentage of USG-assisted service delivery points (SDPs) offering FP/RH counseling or services. *	**59.5%**	**59.5%**	**N/A[1]**	**N/A**	**N/A**	**N/A**	**70%[2]**
2. 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%**	**N/A**	**N/A**	**N/A**	**N/A**	**0%**

[1] Non-Applicable. This indicator cannot be divide in quarters because it depends on external factor.
[2] This data corresponds only to the Health Units in Luanda.
*This data cannot be divided by quarter because it depends on external factor that cannot be controlled by the Project.

3. Couple years protection in USG supported programs.	**59,054**	**59,054**	**14,764**	**14,764**	**14,764**	**14,764**	**54,832/ 59,054 (92,8%)**
4. Percentage of health facilities whose providers reported a Quality of Care score >= 80% for management of FP services (+).	**N/A**	**40%**	**N/A**	**20%**	**30%**	**40%**	**N/A[3]**
5. Number of health care workers who successfully completed an in/service training program.	**192**	**280**	**50**	**95**	**95**	**40**	**23/280 (8,2%)**
6. Number of protocols finalized and approved.	**4**	**4**	**1**	**1**	**1**	**1**	**1/4 (25%)**
7. Number of people trained with USG funds.	**307 (not defined)**	**400** (non-health worker)	**30**	**150**	**150**	**70**	**63/400 (16%)**
8. Number of USG-assisted community health workers (CHWs) providing Family Planning (FP) information, referrals, and/or services during the year.	N/A	30	30	0[4]	0	0	**30/30 (100%)**

Note: For indicators 1, 2 and 3 data from some health units sometimes arrive with delays. If health units send data related to reporting period, only after the close out of the period, results for previous quarters might be affected

4.3 Major Achievements during Q2:

- **Strengthen Advocacy with MoH and Partners**

PSI and PSM worked together to draft an explanatory booklet about the benefits of the FP2020. The main goal was to prepare a document that could be given to the Ministry of Health to facilitate advocacy on family planning and, especially, to propose the adoption of FP2020 indicators. A draft was made and discussed among partner organizations at the Technical Working Group for Sexual and Reproductive Health (TWGSRH). The TWGSRH members recommended the addition of information related to local statistical data and costs and benefits such as: (1) Government of Angola (GRA) spending for childbirth in public hospitals per year; (2) GRA spending on obstetric fistula treatment per year; (3) Socioeconomic benefits of investing in Long Acting Reversible Contraceptives (LARC), instead of short term contraceptives; (4) Data on Maternal Mortality rate in Angola; and (5) Teenage pregnancy rate.

In Q2, one TWGSRH meeting was conducted. In the last meeting, FP2020 and Reduction of Maternal Mortality were discussed. The TWGSRH agreed to continue working on the FP2020 booklet to be presented to the MoH, to reactivate the Maternal Mortality Committee, and to map all the nonprofit organization throughout the country to ensure SRH/FP support at all 18 provinces. PSI is assuming the secretariat of the Technical Working Group for Sexual and Reproductive Health (TWGSRH) lead by the Department of Reproductive Health from the DNSP. Every two months, Family Planning partners come together to discuss SRH/FP issues and propose solutions.

RMA, one of HFA's implementation partners, has a very strong relationship with the Ministry of Family, Social Affairs and Women Promotion (MASFAM). RMA has been supporting and promoting activities with MASFAM to reduce Gender Based Violence and promote gender integration. To celebrate the International Women's Day, RMA organized with MASFAM a Health Fair to promote behavior change towards contraceptive use and family planning service. The Health Fair happened at Casa da Juventude de Viana (Viana Youth's House). Among the visitors, there were two representatives of the Viana Municipality Health Department, USAID FP Focal Point and a representative from ANGOBEFA, a local NGO dedicated on reproductive health. About 1,151 people participated in the fair (visited booth and or/received FP counseling). The large majority were youth between the ages of 19-25 years old.

- **Gender integration**

The gender integration training has strengthened HFA activities. After the training was conducted, several adjustments were made to the FY18 workplan to promote gender integration recommendations. These changes are now reflected in the Workplan, SBCC activities and trainings. For instance, trainings are not only including

[3] This information was not measured in Q2. It will be measured in Q4.

[4] The target of CWH providing FP services was reached in Q1. However, CWH will receive refresher trainings during the year.

FP content, but also discussion sessions on gender norms and power in order to make participants reflect on the different social involvement of women and men related to healthcare.

- **Integration between HFA FP and HIV components**

To promote integration among HIV and FP activities, PSI and MSH jointly organized a training on FP counselling for HIV activists and health care providers. The training included the following topics: a) long and short-term contraceptive methods and its efficacy, b) individual and couple FP counseling, c) gender and health decision making. It was conducted with 6 healthcare providers and 33 HIV activists to provide FP counseling to HIV+ patients.

- **Build partnership with the leadership:**

A visit was made to Huambo province to present HFA to the new Provincial Health Director (DPS), Municipal Health Directors (DMS), FP and Malaria Focal Points. This meeting was essential not only to present the project, but also to build a strong relationship with the DPS Director, Dr. Jovita André, and the municipal directors. The HFA family planning team and USAID's FP focal point participated in the meeting. It was decided that HFA would be able to continue working in Huambo province to support FP activities, such as training for health care providers and supportive supervision. In addition to that, HFA and USAID visited three USG-assisted service delivery points in Londuimbali, Ekunha and Ukuma municipalities. Across these three municipalities, similar problems were found, namely: stock out of contraceptive methods, need for a refresher training on FP and statistics (reporting forms). These findings were shared with the Logistics Technical Working Group at DNSP.

In Luanda, a similar meeting was promoted by the Provincial Health Office of Luanda (GPSL) to understand partners' involvement in health areas at municipal level, to coordinate and integrate organizations' activities with GPSL and, in particular, with new Municipal Directors. This meeting helped the GPSL better understand the need to cooperate more with partners to rationalize funds and avoid duplication.

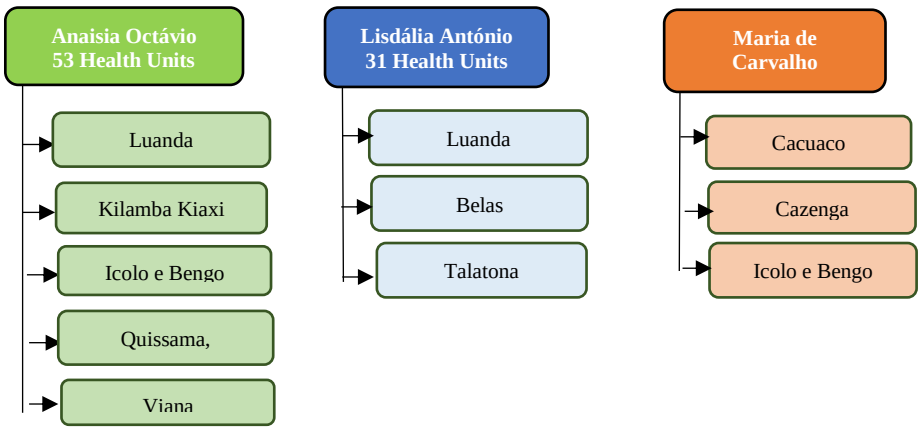
- **Involvement of the Family Planning focal points and providers in PF activities**

Collaborative actions between community health workers (CHW) and health providers in the health units where SBCC activities are being carried out. Health care workers are working with CHW as a team. When the healthcare provider is seeing clients, the CWH provides information on family planning to those clients that are at the waiting room. With this model, healthcare providers can work faster and reduce the waiting time.

Family planning focal points also have shown great involvement during supportive supervision to the environmental check list. They have been doing joint supervisions when needed with PSI's Quality Assurance (QA) supervisors. The joint supervisions ensure to the health providers that PSI is a partner who is working to support the MoH in strengthening integrated SRH and FP. About 144 supervision visits were conducted in Q2 on 99 health units across all nine municipalities of Luanda. Those health units that needed assistance with statistical data and other technical support were visited twice.

- **Improved Supportive Supervision:**

To improve supervision coverage at health facilities in the province of Luanda, two more supervisors, such as service providers, are being hired to work two or three times a week. In this sense, the province of Luanda will have a total of three nurses, one supervisor and two technical assistants. The supervisor and technical assistants of PF will be distributed in nine (9) municipalities, namely: Belas, Cacuaco, Cazenga, Icolo-Bengo, Kilamba-Kiaxi, Luanda, Quiçama, Talatona and Viana. Each of the nurses will be responsible for a number of municipalities and their respective health units (US). Please see the chart and table below for better understanding:



Activity	Achieved in Q2
Number of USG-assisted service delivery points (SDPs) offering FP/RH visited	**99**
Number of supervision visits conducted	**144**
Number of people reached during the Health fair	**1.151**

- **Improved RMA Capacity in Management:**

PSI conducted management analysis of RMA and suggested a new management structure with special focus on finance and procurement departments (see below). The proposed structure is compliant with the segregation of duty principle. Other support provided by PSI to strengthen the capacity of RMA are:

- PSI has developed job descriptions (JDs) for each position and started recruitment process;
- PSI has developed tests for accounting, HR and logistics positions and, together with RMA, all interviewed candidates are being tested;
- We are also reviewing the current staff capacity and defining a capacity building plan (mostly on-job).
- With the help of PSI, RMA has identified a new office, near PSI, and will move to the new premises in May.
- PSI is assisting RMA in opening a new bank account with Standard Bank.

4.4 Major Constraints Faced during Q2 FY18:

In the second quarter of the FY18, the major constrains were related to:

- Delay in obtaining response from decision makers: partners from the GRA usually take long to answer requests for meetings and trainings. To overcome that, requests are being placed up to two months prior the planned activities.
- Political Changes in Leadership: the change of department heads directly affected some activities. For example, the National Communication Strategy in FP is pending on approval from the new head of Health Promotion's Office. To overcome this situations, meetings and work sessions were scheduled for finalization of the strategy during Q3.

4.5 Recommendations for Q3 and Q4 FY18:

- **Strong Integration among HFA components:** It is important to promote FP in HIV services, during LLIN distribution, malaria case management for pregnant women, and include the FP component in DHIS2 to strength the health system.
- **Visibility of HFA activities**: more activities, such as participation on special dates celebrated by the MoH, publishing a biweekly newsletter and building a partnership with the MoH's Department of Communication and Image. This partnership will allow HFA to coordinate with MINSA national campaigns to promote family planning in the entire country and therefore reinforce the enabling environment.
- **RMA will continue to engage in dialogue with the Parliamentarian Women Group** to advocate for the increase of reproductive health line budget in the in the National Budget. This activity will be implemented in coordination with UNFPA and will be presented at Technical Working Group with partners.
- **RMA will conduct a workshop with the Network members** to disseminate lessons learned since inception and develop a plan of action of the resolutions discussed at the **International Women's Conference** in New York.

4.6 Proposed Targets for Q3 – Q4 FY18:

In Q3 and Q4, HFA will focus on the following activities:

- Providing FP trainings for healthcare providers at provincial and municipal levels. Training will happen in Luanda and Huambo provinces and will include providers of all municipalities in both provinces.

The first phase of the training will be conducted with Municipal FP Supervisors (also known as focal points) to refresh their training and FP skills. The second phase of trainings will be conducted with providers from all municipalities in Luanda (Belas, Cacuaco, Cazenga, Icolo-Bengo, Kilamba-Kiaxi, Luanda, Quiçama, Talatona and Viana) and in Huambo (Bailundo, Ecunha, Huambo, Caála, Catchiungo, Londuimbali, Longonjo, Chicala-TCholoanga, Mungo, Tchinjenje and Ukcuma);

- Providing FP trainings to youth groups, members of the Christian Church Counsel (CICA) and other non-healthcare providers. This activity will be aligned with the National Communication Strategy, since it has recommendation to work with religious leaders and members as secondary audience. Other activities will be coordinated with the Ministry of Youth, since they work with youth groups.
- Disseminate, at provincial and municipal levels, the FP norms and protocols such as the:
    - National Family Planning Strategy 2017-2021;
    - Strategy for Integral Attention for Adolescents and Youth 2016-2020;
    - Manual of Orientation for Manual for The Notification, Care and Referral of Cases of Suspected or Confirmed Domestic Violence, Sexual Violence and Other Violence;
- Supporting the Department of Health promotion to finalize, print and disseminate the national FP/RH Communication Strategy.

The proposed targets per indicator are presented in the table below.

Performance Indicators	Quarter targets for FY18	
	Q3	Q4
1. Percentage of USG-assisted service delivery points (SDPs) offering FP/RH counseling or services.	**N/A***	**N/A***
2. 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.	**N/A***	**N/A***
3. Couple years protection in USG supported programs.	**14,764**	**14,764**
4. Percentage of health facilities whose providers reported a Quality of Care score >= 80% for management of FP services (+).	**30%**	**40%**
5. Number of health care workers who successfully completed an in/service training program.	**95**	**40**
6. Number of protocols finalized and approved.	**1**	**1**
7. Number of people trained with USG funds.	**150**	**70**
8. Number of USG-assisted community health workers (CHWs) providing Family Planning (FP) information, referrals, and/or services during the year.	**Completed in Q1**	**Completed in Q1**

**** Non-Applicable. This indicator cannot be divide in quarters because it depends on external factor.***

4.7 Environmental Mitigation Monitoring Plan (FY18):

Activities under IR4 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 Backround

5.1.1 Finance and Governance Strengthening

Under the Governance and Finance component, USAID defined the main topics/areas to be prioritized as follows:

- Strengthen provincial and municipal capacities in annual planning, budgeting, and monitoring interventions in Zaire and Lunda Sul Provinces.
- Strengthen management capacities within the NMCP, starting with a comprehensive institutional assessment, followed by building capacity in annual planning, budgeting, human resources, and financial management.

- Estimate the cost of iCCM interventions regarding malaria, diarrhea, and pneumonia.

Nevertheless, the MOH has yet not approved implementation of the first and second priority areas. With that in mind, USAID and PMI have agreed that HFA should focus on the third priority area during FY18: *develop a cost analysis exercise of the iCCM intervention (malaria, diarrhea, pneumonia)*.

5.1.2 Health Information System Strengthening

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

- Support the MOH in developing/improving DHIS2 as the national platform for health information system, in coordination with other partner/stakeholders;
- Strengthen the municipal, provincial and central level capacities in data insertion, data analysis, and data use in DHIS2 for decision making.

5.2 Targets for FY18

5.2.1 Finance and Governance Strengthening

Given that the MOH has not yet approved the two first key activities intended for FY18, HFA will focus its effort on implementing a cost analysis exercise on the iCCM intervention (malaria, diarrhea, pneumonia) for the provinces of Zaire and Lunda Sul.

5.2.2 Health Information System Strengthening

PMP indicators on Health Systems Strengthening are presented in the table below. They reflect the key efforts of DHIS2 implementation in all 61 municipalities of the six PMI provinces. The foundations for DHIS2 implementation were set up during Q1 of FY18 with the development of the DHIS2 Road Map. In the remainder of Year 2, HFA intends to:

- Roll out DHIS2 and develop a capacity building plan for municipal, provincial, and central levels to be implemented in Q2 and Q3;
- Make DHIS2 fully functional by Q4 in the six PMI provinces;
- Monitor DHIS2 data entry, analysis, and data use for decision making.

Performance Indicators	**Baseline 2015-16**	**Target 2018**	**Quarter targets for FY2**				**Achieved in Quarter 2 / Quarter 2 Target**	**Achieved in Quarter 2 / Year Target**
			Q1	**Q2**	**Q3**	**Q4**		
Number of DHIS2 users trained within MOH with USG assistance *	N/A	**142**	N/A**	**8**	**50**	**84**	**8 / 8 (100.0%)**	**8 / 142 (5.6%)**
Percent of municipal HMIS reports submitted on time and complete (every quarter) ***	N/A	**70%**	N/A**	N/A**	N/A**	**70%**	**N/A**	**N/A**
Number of municipal authorities meeting quarterly to review HMIS data and incorporate feedback in reports ***	**N/A**	**43 ł**	**N/A****	**N/A****	**N/A****	**43**	**N/A**	**N/A**

** It assumes training 2 people at municipal level (2 x 61=122), 2 at provincial level (2 x 6=12), 2 at central level (GEPE/GTI), and 6 trainers of trainers (TOT);*
*** Not targets for some indicators in Q1, Q2 and/or Q3 due to the roll out phases of DHIS2;*
**** Targets were changed with respect to PMP to go in line with recent developments of DHI2 Road Map and HFA implementation plans;*
ł It corresponds to 70% of 61 municipalities (total number of municipalities in 6 PMI provinces).

5.3 Major Achievements during Q2 FY18:

5.3.1 Finance and Governance Strengthening

The main achievement of this component was securing collaboration with the new Director of the National Department of Public Health (DNSP), Dr Isilda Neves, by sharing HFA's scope of work and results expected, and defining the timing of interventions. Dr. Joseth Rita Sousa, Head of the Department of Health Promotion at DNSP, was assigned as the technical counterpart to fulfill two objectives: a) to represent the DNSP throughout HFA's implementation, and b) to serve as a link with other MOH departments, the Ministry of Territorial Administration (MAT), and the Social Support Fund (FAS). Following this assignment, Dr Daniel Minji, National Coordinator of Local Development at FAS, was contacted and engaged in the activities.

a) Strengthen capacities for costing analysis of iCCM

In Q2, HFA presented the iCCM costing analysis activity to Daniel Minji/FAS, who recognized that conducting such analysis was timely, relevant, and strategic. FAS recommended engaging the following partners as part of the exercise: municipal malaria focal points, municipal supervisors, provincial health directors, the Executive Coordinator of MAT (Ministry of Territorial Administration), IFAL (Institute for Training on Local Administration), FAS (Social Support Fund), the NGO ADPP (*Ajuda de Desenvolvimento de Povo para Povo Angola*), and World Vision, an NGO. Additional advances include:

- Development of a scope of work for the costing analysis;
- Development of a budget for the iCCM costing analysis; and
- Submission to USAID (through PSI) of a request for approval of the short-term technical assistance visit (STTA).

b) Strengthen management capacity of the NMCP

HFA had planned to develop a comprehensive institutional assessment (using the MOST tool developed by MSH) to, then, begin processes to improve the finance and human resource management capacities of the NMCP. USAID and PSI expected that, after the institutional assessment was completed, HFA would have a better idea of NMCP's priorities and where technical assistance and support could strengthen their management capacity. This proposal, however, has been temporarily postponed, since no agreement with NMCP-DNSP has so far been reached regarding their institutional assessment. HFA will continue advocating for the implementation of this second activity or try and identify other ways of assessing the needs for capacity development of the NMCP.

Note: *the information above was true at the time of the reporting period (Jan-Mar/18). Changes and update to this activity will be detailed in Q3 Report.*

5.3.2 Health Information System Strengthening

DHIS2 and Health Digital Systems

During Q2 FY18, HFA focused its efforts in doing prep work for the roll out of DHIS2 in PMI provinces. To that end, it developed a set of manuals and systems that will facilitate training and daily use of DHIS2:

- User manual
- Supervisor manual
- Admin and support system (in progress)
- DHIS2 governance rules (helping draft the MOH manual)
- DHIS2 form configuration (recently approved malaria form with iCCM key indicators, as well as daily collection forms for outbreaks of measles and Zika virus (requested by the MOH)
- Capacity building of GEPE/GTI: on-job coaching of GTI technicians on a weekly basis
- Support of DHIS2 Academy (one person from GTI and 1 from HFA participated in the Maputo Academy Level 1)
- Got the overall approval of the Roll Out plan for the first three provinces, regarding timeline, target population for training, etc.

HFA also hired six IT professionals and trained them in DHIS2. These personnel will play the role of TOT trainers and will be based in the PMI provinces during the first year of the DHIS2 roll out, providing daily support to municipal and provincial level health personnel in IT and DHIS2 problems they may encounter. It is expected that, with this strategy, health personnel will develop faster its DHIS2 skills and will be more likely to using DHIS2 as the platform for data reporting, analyses, and decision making. In addition to the six IT, two internal HFA personnel were trained, reaching a total of eight persons as expected in the PMP.

In March 2018, HFA, in coordination with USAID-PMI Angola, organized a three-day Health Tech Camp with funds from the US State Department. The Health Tech Camp gathered participants from the MOH, donors, and private sector[5] who identified current problems of interoperability between DHIS2, Open-LMIS, and other digital health information systems, and discussed strategies to overcome such problems. By the end of the Tech Camp, participants agreed that one key step to reaching interoperability is to develop a master facility registry and use OpenHie as a platform through which DHIS2, Open-LMIS, and other digital system can talk to each other. It is expected that a follow-on activity will take place during Q3-Q4 to develop an interoperability prototype.

As planned in the previous quarter, HFA presented the MOH and partners with a PSI supervision tool to measure the quality of health service provided to the MOH and partners (HNQIS: Health Network Quality Improvement Software). HFA did so in the context of the Health Tech Camp, where public and private sector partners presented other digital health systems tools. HNQIS was well received, overall.

Monitoring Activities with the NMCP-MOH

During Q2 FY18, the HFA Malaria Advisor from NMCP supported the MOH on a wide range of activities. The most important ones are presented below:

- Updating of data collection tools (malaria template with iCCM component and draft of user manual. (see documents attached);
- Training of national and provincial officers on M&E (malaria data collection forms and their relevance). The M&E advisor embedded at the NMCP was one of the main facilitators (others being the Malaria focal point and Malaria Monitoring Officers at NMCP). People trained were: 42 provincial officers; 18 OPPMs, 18 Provincial supervisors and 6 OPMs from PSI, among others supporting data analysis (malaria indicators at provincial and national level for bilateral monthly meetings between NMCP and USAID/PMI);
- Contributing to data use for planning and distribution (quantification of malaria commodities needs for 2018-2019);
- Developing NMCP technical documents in coordination with WHO (National M&E Plan drafted, M&E Plan, for the recently created "*sala de crise*" of the MOH (see attached a draft of the new M&E plan). In this regard note that the MoH created the "*sala de crise*" due to the increase of malaria and cholera cases in several provinces, with the purpose to monitor on a daily basis these outbreaks and take immediate actions. Within the "*sala de crise*", the MOH created several *commissions*, one of them being the *M&E commission* (composed by the Director of Health Inspection Department, the HFA M&E adviser, and 2 NMCP monitoring officers);
- Participating in the development of the Malaria Concept Note (approved) and the Health Strengthening System Concept Note (recently submitted to the GF).

Research Activities

Apart from the DHIS2 and monitoring activities, there was another research coordination activity happening in Q2 FY18:

- **OR: Southeast Asian Migrant Study.** This study was first presented by USAID/PMI Angola to the MOH (DNSP) for its approval. In Q2, PMI/DC also provided its final concurrence to the study, after which HFA presented the first draft of the protocol, based on conversations with CDC/PMI.

[5] MoH, INLS, PNCM, DNSP, GEPE, GTI, CECOMA, USAID, PMI, WHO, PATH, PASS2, PSI, PSM, UNICEF, World Vision, private sector (Unitel and developers of Appy Saude, +Vida and Stop Malaria)

The first draft focused on preventive care and health care seeking behaviors of Southeast Asian migrants. After follow-up conversations with CDC, HFA included a blood testing component to identify malaria prevalence and types of strains among migrants. Depending on the added costs of this component, its actual inclusion during fieldwork will be decided. For the implementation calendar, see **section 5.6**.

5.4 Major Constraints faced during Q2 FY18:

5.4.1 Finance and Governance Strengthening

As with other components of the HFA project, the major constraint has been the delays in approvals by the MOH to proceed with priority activities of the workplan. As a result, the provincial and municipal interventions planned under the IR5 continue to be on stand-by.

5.4.2 Health Information System Strengthening

Although the development of the DHIS2 Road Map in Q1 2018 was a corner stone to align partners and MOH in timelines and most activities, subsequent coordination by the MOH has not always been strong, creating the following challenges:

- **Lack of equipment for DHIS2 roll out:** delays in approvals for Global Fund (GF) procurement by the MOH can jeopardize the roll out in several provinces. According to the DHIS2 roll out, GF money could be used to purchase one computer for almost every municipality in the country (161 municipalities out of 164), covering all the 61 municipalities in the six PMI provinces. Nevertheless, the MOH has barely started the procurement process and this can take several months.
  So far, GTI has offered 21 computers donated by the World Bank to start the roll out, out of the 43 that had originally been promised to cover the initial three provinces: Uige, Malanje, and Lunda Norte.
- **Synergies among partners not always reached:** implementers have their deliverables, indicators, and workplans that they have to meet, making harmonization challenging. This is accentuated by the lack of strong coordination by the MOH.
- **Level of capacity of people:** people from MOH assigned to accompany HFA to provinces and DHIS2 trainings at municipal and provincial level do not always have the necessary skills to do so. MOH has assigned some personnel who have not participated previously in any DHIS2 academies, leaving aside those who have actually attended. This requires greater prep work from HFA in order to train the assigned MOH personnel at central level, before going to the provinces.

5.5 Recommendations for Remaining of FY18:

5.5.1 Finance and Governance Strengthening

Establish a mechanism of communication and coordination for implementing HFA strategies with key partners involved in governance and financing topics, including NHPD, NMCP, GEPE, and FAS.

5.5.2 Health Information System Strengthening

Overall, the major recommendation is to work toward improving synergies among partners in the implementation of DHIS2. It is important to resume the monthly coordination meetings within the Extended Technical Working Group to know what other partners are doing. For that, leadership within the MOH will be needed, since they have the prerogative to organize and invite attendants those meetings.

Another recommendation is to continue supporting the MOH in improving the governance rules and in building the DHIS2 architecture that the health programs need. It will be important to use present and new governance rules and changes on DHIS2 architecture at the Extended Technical Groups, so all partners can suggest changes and work aligned with the MOH governance rules.

Finally, improving the culture of data use at all levels is very important for the success of the project. For that, HFA will allocate efforts in continuous capacity building with support from HFA personnel based in each province, and through frequent supervision visits to the field by central level personnel.

5.6 Proposed targets for Q3 and Q4 FY18:

5.6.1 Finance and Governance Strengthening

- **Strengthen capacities for costing analysis of iCCM**

HFA will provide technical assistance to strengthen capacities for developing a costing iCCM analysis. The initial focus will be a phased costing exercise, starting with malaria, diarrhea, and pneumonia:

- **Stage 1 - Preliminary work:** HFA will conduct a review of the existing literature on community health in Angola and MOH strategies related to community health;
- **Stage 2 - Data collection:** HFA will conduct data collection in Angola at all levels of the health system through meetings with key stakeholders and implementing partners, an expert panel, and field data collection through interviews with CHWs (ADECOS) and their supervisors;
- **Stage 3 - Analysis:** Based on the data collected, HFA will model the ten-year (2018-2028) costs and impact of national scale-up of the community health program;
- **Stage 4 – Training:** HFA will conduct a three-day training with MOH personnel on the use of the MSH/UNICEF Planning and Costing Tool (see attachment);
- **Stage 5 – Validation of results:** HFA will present and validate the results of the study with MOH and key stakeholders.

Once HFA completes the costing exercise, the project will facilitate a broad meeting with MOH, NMCP, and DPS authorities to share findings and recommendations for the costing analysis.

5.6.2 Health Information System Strengthening

- ***DHIS2 Roll Out and Interoperability among Different Digital Systems***

Roll out of DHIS2 will initiate in 3 provinces in Q3 and will be expanded to the other 3 provinces in Q4.

The expansion will be in a phased way, starting with one province and learning from it to improve the roll out in subsequent provinces. HFA will be accompanied by GTI-GEPE and other MOH personnel (NMCP), who will be responsible for leading certain sessions of the training. The roll out will start in provinces where GEPE has already provided training on basic monitoring and evaluation competencies (existing data collection forms and how information is used) using funding from the Global Fund ATM. The idea is that, by starting in these provinces, the health personnel at municipal and provincial level will be better prepared to understand the use and benefits of DHIS2. It is expected that, by the end of the FY18, DHIS2 will be fully implemented and that 70% of the municipalities will be submitting reports through this platform on time. It is also expected that at least 70% of the municipal authorities in the six PMI provinces will meet at least quarterly with provincial level authorities to analyze reports and to make decisions based on DHIS2 information.

- ***OR: Southeast Asian Migrant Study***

It is expected that the final study design will be submitted to CDC's IRB committee in May 2018. The IRB takes approximately three months to grant approval (likely in August). That means the fieldwork might start in September 2018 with preliminary results for the quantitative component by Q1 FY19. The qualitative component of the study (understanding the "how" and the "why" of findings provided by the quantitative component) will take place in Q1-Q2 FY19.

5.7 Environmental Mitigation Monitoring Plan for FY18:

Activities under IR5 (Governance/Finance and DHIS2) have a status of categorical exclusion and do not require reporting.

This is the revised Quarter 2 Report for FY18.

Luanda, July 10th, 2018.

List of Annexes

- **Annex 1 – Success Story (HIV/AIDS)**

- **Annex 2 – Success Story (LLIN Distribution)**

- **Annex 3 – HFA Communication Plan (May 2018)**

- **Attachments under Result 2 – Malaria Case Management**

1. Copy of updated "***Guiões de Supervisão***";
2. Copy of unified "***Lista de Presença***";
3. Copy of updated "Training and Supervision Plans";
4. Copy of the " National Protocol for Treatment of Malaria + TIP"
5. Copies of "***Proposta CENFFOR***" and "***Relatório de Formação de Formadores (CENFFOR)***"

- **Attachments under Result 5 – HSS**

6. Modelo Relatório Unidade Sanitária (malaria com iCCM)
7. Guiao Preenchimento de Relatorio Mensal de Malaria p/ US
8. Draft Novo Plano de Monitoria e Avaliacao PNCM (2018-2020)
9. Plano de Actividades da Comissao de M&A
10. Guiao de Levantamento de Gestao de Residuos
11. Environmental Compliance (presentation)
12. Biosseguranca (presentation by NMCP/DNSP)

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Success Story

Improving quality of life through peer support and counseling

HIV positive counselors like Manuela help pregnant women and discordant couples to live positively

Manuela dos Santos is one of HFA's Patient Assistant Facilitators (PAF), helping people stay on treatment and live positively, identifying new people living with HIV, and linking them to care and treatment.
Photo: USAID Health for All Project

"I feel happy and realized! Sharing my story helps people cope with a positive diagnosis and get the treatment they deserve and need to fulfill their lives."

Today, Manuela is pregnant with her third child, lives in a sero-discordant relationship, and has had an undetectable viral load for 6 years.

Manuela dos Santos was 25 years old when she gave birth to her second child. It was after delivery that she found out that she was HIV positive. For weeks, she feared how her family and friends would react to her diagnosis and maintained her status a secret. Fortunately, her child was born HIV negative, but Manuela's health quickly deteriorated as she lost weight, sleep, and the ability to care for her newborn child.

Eventually, Manuela's illness was impossible to hide – she had developed AIDS. She broke down in tears to her sisters and brother in-law, who, to her surprise, offered support and care. Her family accompanied her to Hospital Esperanza for treatment, though her future seemed uncertain. The first few weeks on antiretroviral treatment were difficult, as she battled with a low CD4 count and strong side effects. Nevertheless, she thought of her two children and persisted.

Today, 10 years later, Manuela shares her story with people who struggle to cope with a positive diagnosis. As a PAF (Patient Assistant Facilitator/USAID-HFA Project), she accompanies sero-discordant couples and provides counseling and support to people living with HIV, helping to build the skills they need to cope with the illness and continue to lead productive lives. As a PAF, Manuela often serves as the link between people living with HIV and the health system, ensuring treatment adherence and helping to identify new HIV contacts in the community. She counsels pregnant women to know as early as possible about their HIV status in order to begin treatment immediately if the test is positive, and thus protect their children from the virus.

PAFs are part of the HFA Project's innovative approach involving a team of advocates and educators who extend the reach of the health system into communities, helping people stay on treatment and live positively, identifying new people living with HIV and linking them to care and treatment. The HFA Project trains and supports 16 PAFs across seven health facilities in Luanda – most of them people living with HIV – strengthening the capacity to deliver high-quality care and treatment for HIV and AIDS. The HIV/AIDS area of HFA, led by Population Services International and implemented by Management Sciences for Health, is piloting a continuum of care model that will increase the number of people receiving testing, counseling, and treatment for HIV.

This success story is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the HFA Project and do not necessarily reflect the views of USAID or the United States Government.

HEALTHFORALL

Success Story

The Covered Seven!

The engagement of the society as a whole and from different sectors was essential for the positive outcome in the LLIN mass distribution campaign.

A group of activists managing difficulties felt on the ground while distributing LLINs in some remote areas.
Photo: USAID HFA Project

Prevention is the first step in controlling Malaria and in decreasing the number of people infected with the plasmodium.

In total, 3,189,734 LLINs were distributed to 5,719,691 beneficiaries, which included 151,630 pregnant women and 900,202 children under the age of five.

Each year thousands of people still die in Angola due to Malaria, despite significant efforts made by several organizations (public and private) in partnership with the Angolan Government.

Prevention is the first step in controlling Malaria and in decreasing the number of people infected with the *plasmodium*. It is clear that, even receiving hundreds of thousands of mosquito nets donated to the country, they are worthless if they do not reach the people they are intended for. This is especially true when referring to the 18 provinces of Angola, where the health system struggles to provide basic quality care to the most vulnerable people. In April 2018, WHO posted an update on the Malaria factsheet, mentioning that 'the most cost-effective way to achieve prevention is by providing Long lasting insecticide nets (LLINs) free of charge, to ensure equal access for all. In parallel, effective behavior change communication strategies are required to ensure that all people at risk of malaria sleep under a LLIN every night, and that the net is properly maintained.'

In March 2017, under the Heath for All (HFA) project led by Population Services International (PSI), funded by USAID and in coordination with the Angolan National Malaria Control Program (NMCP), coordinated Phase 1 and Phase 2 of LLINs mass distribution that was done in five hyper-endemic provinces (Malanje, Kwanza Norte, Kwanza Sul, Uíge, Zaire) and two hypo-endemic (Cunene and Namibe). The seven provinces were universally covered with LLINs between May and December 2017, reaching 2.859.846 number of households, 151.630 number of pregnant women and 900.202 number of kinds under five years of age. The overall goal of this campaign was to increase LLIN access and use by 30%, while helping the NMCP cover at least 80% of the target population with at least one vector control prevention measure.

Not only HFA and NMCP were involved in the communication of this mass distribution campaign, but also different actors in the society were engaged to share and testify the importance of the net use: activists, church representatives, sobas, among others, in a total number of 356 people. Private sector engagement also marked its presence with UNITEL's contribution, who sent a total number of 838.395 reminder messages in the targeted provinces, to make use of the nets that have been distributed. Some examples of these messages were '*Sleep under a LLIN always, every day and every night*', '*Sleeping under an insecticide-treated mosquito net is an effective way to prevent malaria*.'; '*Malaria is a disease transmitted by mosquito bites.'* and *'Pregnant women and children under 5 are more vulnerable to developing severe malaria.'*

In general, several improved outcomes were reached that made this mass distribution campaign a success. However, universal coverage and the contribution for an effective behavior change communication carried out by several entities of the society, are to be highlighted as the main success factors.

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HEALTHFORALL

Communication Plan

Project Name:

Health for All

Donor and lead organization	: USAID; PSI (prime)
Project Dates	: January 17th 2017 – January 16th 2022
Project Chief of Party	: Paulo Proto
Project Communication Partner	: Paulo Proto and Anya Fedorova
Date of issue	: May 9, 2018
Version No	: v1.1

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Document Change Control

The following is the table control for the revisions to this document, which should be made every six (6) months.

Version Number	Date of Issue	Author(s)	Brief Description of Change
Version 1.0	April 30th, 2018	Natascha Levin	Initial version for review and comment
Version 1.1	May 9th, 2018	Natascha Levin	Version submitted to USAID
Version 1.2			
Version 1.3			
Version 1.4			
Version 1.5			

Definition

The following are definitions of terms, abbreviations and acronyms used in this document.

Term	Definition
ACT	Artemisinin combined therapy
AFENET	African Field Epidemiology Network
AOR	Agreement Officer Representative
BCC	Behavior Change Communication
CDS	Centers for Disease Control
CECOMA	Central Unit for Procurement and Provision of Medicines and Medical Supplies of Angola
CoC	Continuum of care
CSC	Contraceptive Security Committee
DHIS2	District Health Information System 2
DNSP	National Directory of Public Health
DPS	Provincial Health Directory
FAS	Fundo de Apoio Social (Ministério da Administração do Território MAT)
FP / RH	Family Planning / Reproductive Health
GEPE	Gabinete de Estudos, Planeamento e Estatística - MoH
GTI	Gabinete de Tecnologias e Informação - MoH
HC3	Health Communication Capacity Collaborative
HFA	Health for All Project (USAID)
HMIS	Health Management Information System
HSS	Health System Strengthening
ICAP	Columbia Univerity's Mailman School of Public Health
ICCM	Integrated Community Case Management
IFAL	Instituto de Formação e Administração Local
IGS	General Inspection of Health
INLS	Instituto Nacional de Luta contra a Sida
LLIN	Long Lasting Impregnated Nets
M&E	Monitoring & Evaluation
MCH	Maternal and Child Health
MINSA	Ministry of Health of Angola
MSH	Management Sciences for Health
NMCP	National Malaria Control Program
PBCC	Provider for Behavior Change Communication
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PSI	Population Services International
PSM	Procurement and Supply Management Program (USAID)
RMA	Rede Mulher Angola
SBCC	Social Behavior Change Communication
SIAPS	Systems for Improved Access to Pharmaceuticals and Services Project (USAID)
SRHTG	Sexual and Reproductive Health Technical Group
TH	Tropical Health (UK based NGO)
UNDP	United Nation Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development

Table of Contents

1. Introduction

The Health for All (HFA) strategic Communication Plan provides a framework to manage and coordinate the wide variety of communications that take place during the project. The communication plan covers what messages will be communicated, who will receive the communications, how the communications can be delivered, in which format communications can be made, their frequency and in which indicators evaluation should be based. The communication plan should be frequently reviewed, for an update of the project status.

2. Project's General Description and Objectives

USAID launched the project 'Saúde para Todos' (Health For All, or HFA) in Angola at the beginning of 2017, to support the government's efforts to increase quality health service delivery in the country. The five-year project builds on years of bilateral collaboration and is targeted toward major improvements in health through sustainable approaches and increased country ownership. HFA is led by Population Services International (PSI), who is the prime recipient, and implemented in partnership with Management Sciences for Health (MSH), Rede Mulher Angola (RMA), Tropical Health (TH), and The MENTOR Initiative. Together they form a team of global and local technical experts. The project will deliver a package of health interventions that cover Malaria (Result 1 and 2), HIV/AIDS (Result 3), Family Planning / Reproductive Health (Result 4) and Health Systems Strengthening (Result 5), in selected municipalities and provinces throughout the country, reaching the most vulnerable citizens of Angola.

As the Health for All prime, PSI/A will serve as the program's administrative secretariat, leading responses to mission requests, overseeing partners and implementation of agreements, and serving as the primary contact for USAID.

- For Result 1, PSI/A will lead workshops for the NMCP, DPS, and partners on how to implement distribution, share tools, disseminate mass distribution strategy, etc. as well as lead LLIN distribution in the 18 provinces, with support from selected local partners.

- For Result 2, PSI/A will develop the Provider Behavior Change Communication (PBCC) methodology and tools for Quality Assurance (QA), as well as collection and management of aggregated service delivery data through DHIS2. PSI/A will also lead the implementation of iCCM pilots and the strategy development for all SBCC under Results 1 and 2, and implementation in Lunda Sul, Lunda Norte, and Malanje.

- For Result 3, PSI/A will manage activities developed and implemented by MSH, whose responsibilities include establishing a sustainable model for providing high-quality HIV and AIDS services through the prevention, care, and treatment continuum (CoC), in support of the government's efforts to maintain the country's relatively low HIV prevalence. Interventions are only to be made in the province of Luanda, with possibility of extension to other provinces, as jointly determined by INLS/USAID.

- For Result 4, PSI/A will lead and implement all Family Planning(FP) activities such as reinforcing the enabling environment for Reproductive Health (RH) and FP, advocacy for the Angolan Government and promotion of Family Planning 2020 (FP2020), supervision and QA in Public health facilities in the provinces of Luanda and Huambo, Social Behavior Communication Change (SBCC), among others.

- For Result 5, PSI/A will implement cross-cutting activities at the local level to support specific interventions related with Malaria and FP at provincial and municipal level. HMIS for data integration into the M&E and surveillance system for NCMP, as well as provide staff for NMCP secondment.

HFA's geographic focus can be seen in the table below:

Result	Geographic Focus
Malaria Prevention (Result 1)	LLIN distribution strategy: nation wide LLIN mass distribution: 15/18 provinces (2017/18); All provinces (2022) LLIN continuous distribution: Pilot, in 3 provinces in Year 1-3, scaled up in Years 4-5
Malaria Services (Result 2)	24 municipalities in Zaire, Uige, Cuanza Norte, Malanje, Lunda Norte and Lunda Sul;
HIV / AIDS (Result 3)	Nine priority clinics in Luanda, with possibility of two additional provinces for program expansion
FP / RH (Result 4)	Luanda and Huambo. During Q1, jointly determine number, location of facilities with USAID, DNSP and General Inspection of Health
Health Systems Strengthening (Result 5)	Nationwide. The Team will consult closely with USAID, the National Malaria Control Program (NMCP), DPS and municipal leaders to finalize selection and update new prevalence data when available.

In order to achieve success in HFA project, effective and open communications is critical. Therefore, key communication objectives for this project are:

- To promote and gain support for the HFA Project

- To encourage use of project management best practices

- To give accurate and timely information about the project to all involved partners and departments

- To ensure a consistent message

3. Communication Goals by Result

HFA messages will vary depending on the health area, public health issue addressed, local context, and target audience. Therefore, communication goals will focus on each Result separately, for a clearer and better understanding.

Each result presents a key message that it intends to pass when communicating with the audience. Messages should be revisited regularly, so as to reflect the up to date communication strategy and stage in which the project is in.

a) Result 1. Malaria Prevention

Key message

'*The importance of sleeping under nets, especially for pregnant women and children under 5, and the importance of malaria prevention during pregnancy'.*

Main Goal

- Increased access and use of long-lasting insecticide-treated nets (LLINs) by at least 30% throughout Angola.
- 10.4 million insecticide-treated and long-lasting mosquito nets distributed in years 1 and 2; 1.8 million households with at least one mosquito net treated for every two people.

b) Result 2. Malaria Services

Key message

'The importance of improving malaria services in targeted municipalities, and the importance of correct diagnosis prior to treatment.'

Main Goal

- Improved quality of clinical care services provided in malaria case management.
- 60,660 children will receive combination artemisinin-based therapy (ACTs) among children under 5 years of age who had a fever in the past few weeks and who received an anti-malarial drug.

c) Result 3. HIV / AIDS

Key message

'The importance of testing for HIV to know HIV status, linkages to care, adherence to treatment regimens, and stigma reduction.'

Demonstrate proof of concept: evidence, derived from the HFA Project, demonstrates that the HIV continuum of care (CoC) model can feasibly, effectively, and sustainably achieve its objectives to end transmission of HIV as well as prolong the lives and support the well-being of Angolan people living with HIV.

Main Goal

- Demonstrate to USAID/PEPFAR and the Angolan government that HFA's CoC model for HIV/AIDS prevention and treatment works and effectively contributes to achieving the UNAIDS 90-90-90 goals to end HIV transmission by 2030.
    - To demonstrate results of the CoC model so that USAID (and U.S. Congress and the American people) know that their funds were well spent.
    - To generate active support from and foster collaboration with the Ministry of Health of Angola (MINSA and sub-divisions), so that they continue to implement effective HFA Project strategies and approaches.

- Stimulate internal reflection on and knowledge exchange of practices to prevent and treat HIV among national and international public health experts.
    - To share HFA's experience implementing the CoC model in Luanda province so that the government of Angola can replicate and scale the model to national level (and beyond).
    - To convey that the HFA Project is working to meet the UNAIDS 90-90-90 goals to end HIV transmission by 2030.

d) Result 4. Family Planning / Reproductive Health

Key message

'Strengthened, expanded and integrated FP/RH services at provincial and municipal levels, including information about family planning methods, freedom of choice when selecting FP methods, the importance of birth spacing, and partner involvement.'

Main Goal

- Reinforce the enabling environment by co-organizing regular meetings with other stakeholders of the Sexual and Reproductive Health Technical Group (SRHTG) led by the DNSP, through technical working groups (TWG), strategy documents dissemination, etc.
- Transform attitudes and beliefs of key audiences to FP, SRH issues and gender norms

Intermediate Goals

1: Expand integrated FP/RH facility and community services with coordinated SBCC, with activities such as:

- Meet with the provincial authorities and the IGS to identify clinical capacities, coverage areas and access to develop a priority list of clinics, a training calendar, and supervision plan for providers;
- Work closely with the DNSP Communication Department, the SRHTG, and other communication partners, including UNFPA and HC3, through a national workshop to review and finalize the national FP/RH communication strategy;
- Broadcast the approved 10 RH/FP radio episodes in local radios in Huambo province.

2: Provider-initiated and community-based FP/RH services and counseling are strengthened, reaching youth more effectively:

- Provide youth friendly health services training to health providers at USG-assisted service delivery points;
- Disseminate the National Strategy for Adolescents and Youth Health among health care providers at USG-assisted service delivery points;
- Implement BCC campaigns in maternities to increase youth and adolescent access to SRH/FP services;
- Reach both women/girls and men/boys during SRH/FP Behavior Change Communication (BCC) activities.

3: Contraceptive security supported through an engaged RHWG and coordination with and integration into supply chain activities and systems:

- Meet with PSM to coordinate the co-development process of a Contraceptive Security plan with the Contraceptive Security Committee (CSC). Current CSC members include USAID, UNFPA, DNSP, SIAPS, Central Unit for Procurement and Provision of Medicines and Medical Supplies of Angola (CECOMA);
- Participate on contraceptive security monthly meetings;
- Support the development of a multi-year Contraceptive Security plan.

4: Integrated FP/RH services are expanded through private-sector engagement:

- Meet with USAID to share PSI/A plan to engage private international manufacturer and distributors to support the continuity of procurement and provision of commodities such as Sayana Press;
- Advocacy for the inclusion of private sector in the Contraceptive Security Meetings.

e) Result 5. Health Systems Strengthening

Key message

'Developing a Health Information System entirely integrated into a central platform (DHIS2), that allows for interoperability with other public and private health information systems, as well as collection and analyzes of key information in real time to inform program decision-making'.

Main Goal

Support MINSA in conducting main activities needed to develop a Health Information System for Angola which includes:

- DHIS2 Roadmap at national level to harmonize implementation (2017, Health for All / PSI). There are several partners working in different geographic areas and health areas.

  - Investments in financial and human resources at Heath Facility-level to elevate importance of data collection and entry and continuous training;
  - Improve DHIS2 technical and user manuals to facilitate easy replication of processes by DHIS2 users with different level of expertise;

- Technical support to dashboard development for each health program and coordination of meetings to review data;
- Promote frequent meetings with partners and donors to improve coordination;
- Set up technical working groups at municipal and provincial levels.

- Develop NCMP capacity in DHIS2 use for timely decision making.
- Promote meetings with the *Equipa Técnica Nacional Alargada* (ETNA), to have all members coordinated and working for the same objective and sharing the same information.

4. Private Sector Engagement

A well-designed communication program can explain the role of private interest in creating partnerships to make society, as a whole, more prosperous and equal in terms of opportunities. A systematic approach to communication helps to achieve well-tailored private sector participation projects, serving as a two-way check and feedback mechanism at every stage, from planning through execution. The private engagement process communication offers managers in public institutions and enterprises tools that coordinate well with national health programs and fit economic and social needs. Also, this engagement is the recognition of the role of the private sector in achieving inclusive and sustainable growth and development.

The main objective for creating private sector engagement is to catalyze it for development, in other words, to promote Corporate Social Responsibility (CRS), networking and also facilitation of multi-stakeholder's alliances. The tools and modalities used to reach and maintain a successful engagement are developing a clear and permanent public-private dialogue, mobilizing private finance and harnessing social responsibilities.

The strategy of HFA private sector agents has different forms, such as a) finance partners who donate money that will be used to support HFA activities in certain provinces; b) implementing partners who provide and support HFA activities with materials, services, infra-structures, among others; and c) intermediaries who buy PSI products and donate them to a public health institution. Other forms of partnership are to be analyzed and shall not be excluded.

The agents with whom HFA will engage in partnerships for mainstreaming are from several sectors, such as, construction, tourism and hospitality, insurance companies, Fast Moving Consumers Goods (FMCG), social media, transports, banking, among others. Some of the criteria for partnering with private sector are having a measurable development impact, market neutrality, shared social interests and co-financing in some projects or activities.

Principles for engagement with the private sector are focusing on poverty reduction and health improvement overall, taking a firm level differentiated approach, creating market-based opportunities and putting strong emphasis on results.

An update of the private sector partners list is to be shared with AOR every time changes are made.

5. Target Audiences

This section identifies the audiences targeted in this Communication Plan, as well as the purpose of communicating with each audience.

As mentioned previously, result audiences will vary depending on the health area they work in and on what issues are to be addressed. Therefore, audiences will be presented separately, despite having, in some cases, an overlap of same audiences.

Primary audiences	Result 1 + Result 2	• Residents of malaria endemic areas, particularly mothers of children under 5 years and pregnant women
	Result 3	• Citizens living with AIDS as well as others to be identified in collaboration with stakeholders
	Result 4	• Woman of reproductive age (14-49) looking to delay or space childbirth and their partners; female and male youth
	Result 5	▪ NMCP ▪ GTI / GEPE

Secondary audiences	Result 1 + Result 2	• USAID Angola
		• MINSA:
		  ○ National Directory of Public Health (Direcção Nacional de Saúde Pública-DNSP)
		  ○ National Malaria Control Program (Programa Nacional de Controlo da Malária)
		  ○ FAS (Fundo de Apoio Social)
		  ○ IFAL (Instituto de Formação em Administração Local)
		• The MENTOR iniciative
		• Tropical Health (TH)
		• Gabinete Provincial da Saúde de Luanda, Huambo, Zaire, Uíge, Lunda Norte, Lunda Sul, Cuanza Norte, Moxico, Cunene, Malanje
		• Health Care Providers

	Result 3	• USAID
		• MINSA:
		  ○ National Direction of Public Health (Direcção Nacional de Saúde Pública-DNSP)
		  ○ National Institute for the Fight Against AIDS (Instituto Nacional de Luta Contra a SIDA - INLS)
		  ○ National Institute for Public Health (Instituto Nacional de Saúde Pública-INSP)
		• MSH
		• Direções Municipais de Saúde (PEPFAR Health facilities)
		• Other international HIV community partners: UNAIDS, CDC, ICAP, AFENET, PSM, UNDP, UNICEF
		• Civil society (e.g, Angolan Network of AIDS Service Organizations - ANASO)

	Result 4	• USAID
		• MINSA:
		  ○ National Directory of Public Health (Direcção Nacional de Saúde Pública-DNSP)
		  ○ National Institute for Public Health (Instituto Nacional de Saúde Pública-INSP)
		• Rede Mulher Angola (RMA)
		• Direções Municipais de Saúde (DMS) of Luanda and Huambo
		• Health Care Providers
		• Gabinete Provincial da Saúde de Luanda e Huambo

	Result 5	• USAID

6. Communication message and delivery

The following outlines the targeted audiences, the key communication messages to be delivered, and the method for delivering the information, the communicator, and the frequency of the delivery.

Audience	Message	Delivery Method	Delivery Frequency	Communicator
USAID	Project changes	Email / Meeting	As per request	Chief of Party
	Status Reports	Email	Quarterly	Chief of Party
	Report on meetings with Public Sector Partners	Email	Bi-weekly	Chief of Party
Chief of Party	Status Report	Email	Quarterly	Results 1-5
	Project changes	Meeting	As per request	Results 1-5
	Report on meetings with Public Sector Partners	Email	Bi-weekly	Results 1-5
Chief of Party	Project changes	Meeting	As per request	USAID
	Non-Approved Project changes	Email / Meeting	As per request	USAID
External Partners (USAID + MINSA + secondary recipients)	Status Reports	Meeting: Oral briefing and presentations (slides)	Monthly	Results 1-5 + Chief of Party
Chief of Party	Status Reports	Email	Monthly	Secondary Recipients

7. Communication Message Contents

This section outlines the contents of key communications aspects happening between Results, and between Results and other partners outside HFA team (USAID, MINSA or secondary recipients). For each of the communications below, specific items must be included and respected:

Status Report

- Date
- Status Summary
- Status of Schedule
- Status of Budget when relevant
- Accomplishments Achieved
- Concerns/Issues
- Results Achieves / Next steps

Email for Meeting Invite

- Subject mentioning scope of the meeting
- Location
- Date
- Starting time and Finishing time
- Participants
- Agenda

Report when meeting Public Sector Partners:

- Date
- Location of meeting held
- Participants present
- Objectives of the meeting
- Concerns/Issues
- Results Achieved / Next steps

Project Changes

- Summary of situation
- Initial Goals of Project
- Issues raised
- Project proposed change
- New outcomes
- Budget alterations if necessary

8. Communication Branding Strategy

Information mentioned in this section, is crosscutting to all Results and can be adopted by every area, having in mind that each communication project should have USAID final approval prior to its use.

HFA will use an integrated mix of communication channels to systematically overcome individual as well as social barriers to healthy behavior and motivate the primary target audiences to adopt healthy behavior, as presented in the following chapters and tables.

8.1 Logos

The purpose of this section is to describe the interventions under HFA activity that will be branded, marked, promoted and communicated to beneficiaries and host country citizens. It also details the main activity messages and public communications, activity materials and other items partly or fully funded by USAID that will visibly bear the USAID identity.

Communications must:

- Adhere to HFA Project branding and marking plan set forth in CoAg with USAID.
- For each health area, the following logos are mandatory:
    - **Malaria**: The President's Malaria Initiative (PMI) brand. PSI will seek advice from the AOR in case a simple USAID logo is to be used instead of or together with the PMI logo;
    - **HIV**: the logo of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) will be used in all communication materials in addition to the USAID logo. PSI/MSH will seek advice from AOR in case a simple USAID logo is to be used instead of the PEPFAR logo;
    - **Family Planning**: the USAID logo will be used without any other logos.
- HFA logo is to be used always with one of the logos above.
- Implementing partners in HFA project should not use their organizational logo, unless it is specified and approved by PSI and AOR.

Malaria

HIV / AIDS

Family Planning

HFA – English and Portuguese version

● Any public communication funded by USAID, for which the content has not been authored by USAID, will contain the following disclaimer: "*This study / report / audio-visual / other information / media product is made possible by the generous support of the American people through the United*

States Agency for International Development (USAID). The contents are the responsibility of the HFA Project and does not necessarily reflect the views of USAID or the United States Government."

- PSI will share all branded materials for the Health for All Project with the AOR for clearance prior to printing or publication. Anything marked with the USAID identity will also be cleared by USAID.

- PSI will provide the AOR or other USAID personnel designated in the grant or Cooperative Agreement with two copies of all activity and communications materials produced under the award. In addition, Population Services International will submit one electronic hard copy of all final documents to USAID's Development Experience Clearinghouse, every Quarter.

- Every sub-recipient has to submit all communications for approval to PSI (COP HFA). All official communications and all approvals shall go through the AOR (USAID). AOR will share the materials with the technical leads for HIV, FP, Malaria and PPP to get their technical approval. Their feedback will be given to PSI.

- In the event of changed circumstances in any communication material, PSI, through the AOR, will submit to USAID a request to modify this plan and/or other related documents, such as the Branding Strategy.

- PSI anticipates that messaging materials will be distributed in both Portuguese and relevant languages (ex.: Kimbundo), when applicable.

8.2 Manuscripts, abstracts, presentations and posters

The follow guidance applies to manuscripts, abstracts, presentations on studies, poster and assessments that receive any PMI funding or on which PMI-supported staff are presenters or co-authors:

1. *Affliliations*:
    - For PMI-supported staff: Both PMI and the staff person's agency should be listed (e.g. Jane Doe, US President's Malaria Initiative, US Center for Disease Control and Prevention, Atlanta, GA);
    - For PMI-supported implementing partners: Both the project name and the agency name is preferred (e.g. Jane Doe, USAID MalariaCare Project, PATH, Washington, DC)
2. *Funding:* If PMI funding was provided either for implementation of the study or PMI-suported staff or project staff were involved in the study, it should be acknowldged in the manuscript, presentation or poster. The following text can be used in the acknowledgment section: "Funding for this study was provided by the US President's Malaria Initiative." This text may be more appropriate for posters. Alternatively, the US President's Malaria Initiative can be included in an acknowledgments or funding slide in a presentation.

All abstracts, scientific reports and manuscripts describing work funded by PMI should undergo formal review according to the coauthor's respective agency processes. In additional, all abstracts, scientific reposrts and manuscripts describing work funded by PMI must be submitted to the USAID and CDC Agency Leads (and his/her designees, roles currently served by Larry Barat and Auchuyt Bhattarai), for interagency technical review. The two agency reviewers will have one week to provide any feedback to the submitting coauthors(s). The document will then get routed for PMI policy clearance to the USAID Agency Lead and his/her designee, who will review to ensure adherence to branding, marketing and alignment with overall PMI policy guidance.

8.3 Activity materials

The table below gives us a list of activity materials that each Result can use for their communications with their audiences. It also shows us what materials will be used in the present moment and until the next official revision is made.

The range of activity materials will include, but not be limited to the following:

Category	Result 1	Result 2	Result 3	Result 4	Result 5
Brochures, leaflets, flyers, booklets	X		X	X	X
Posters		X		X	
Dramas			X	X	
Training manuals, workbooks, guides, referral card and tool kits	X	X	X		X
Training briefs			X	X	X
Invitation letters		X	X	X	X
Follow-up correspondence	X	X	X	X	
Mass and mid-media materials: radio spots, billboards, journal article and print advertisements				X	
Job aid posters, flip charts, and referral cards		X	X	X	X
Publications and press releases, activity profiles and abstracts	X	X	X	X	X
Presentations at national and regional coordination meetings	X	X	X	X	X
Studies, research results, assessment tools and evaluations	X	X	X	X	X
Websites and public service announcements				X	
Success Stories	X	X	X	X	X
Reports - Weekly / Monthly / Quarterly / Yearly	X	X	X	X	X
Briefing			X	X	X
HFA brochure					
Videos			X		X
Banners and signs	X	X	X	X	
Email	X	X	X	X	X

8.4 Channels

Communication channels are the means through which people in an organization communicate. Thought must be given to what channels are used to complete various tasks, because using an inappropriate channel for a task or interaction can lead to negative consequences. Complex messages require richer channels of communication that facilitate interaction to ensure clarity.

As per the previous table, it also shows us what channels used in the present moment and until the next official revision is made, by Result.

HFA project will include, but not be limited to, the following channels:

Channel	Result 1	Result 2	Result 3	Result 4	Result 5
Receptions, launch events, and others	X	X		X	X
Training courses	X	X	X	X	X
Symposium and Seminars	X	X	X	X	X
Exhibitions			X	X	X
Fairs of all kind		X	X	X	
Workshops	X	X	X	X	X
Conferences (national and international)	X	X	X	X	
Press conferences, and other public activities		X	X	X	
Local events	X	X	X	X	X
International and national days		X	X	X	
Newsletter	X	X	X	X	X
Social media: blog, Twitter, Facebook, YouTube, LinkedIn, others				X	
Hand delivery	X	X	X	X	
Meetings and group discussion	X	X	X	X	X
Email list		x	X	X	
Local radio and TV stations and newspaper			X	X	

8.5 Timetable

Once objectives, goals, audiences and tools have been identified, quantifying the results in a calendar grid that outlines roughly what the project will be accomplish and when is essential. These are shown in the tables below, where the 5 years project *Health for All* main activities and general steps are shown, divided into Result and timeline implementation (for more detailed information, the Agreement between PSI and USAID should be consulted).

Overall, we can identify 4 different moments, each one essential for the development of the project and with its own specific points:

- The co-diagnose of barriers is the first step that every area in the HFA project has to go through to get a better understanding of the reality in which they are going to work in, the obstacles that will be found along the way, the improvements that need to be made, the resources that will be involved in these improvements, how the budget will be managed and allocated, by prioritizing actions and activities. In sum, a clear picture of the general situation must be mapped, using data available but also doing a research on the ground;

- Co-design health system strengthening approaches is the step that follows and where all the improvements, new project and alterations are documented and put in perspective to assure the best implementation process;

- Co-implement proven interventions is the moment in which all strategic actions identified in the previous two moments are put into action to meet HFA main purpose, which is to strengthen the effective use of Angola's resources to meet the country development needs.

HFA timetable

	#	ACTION	RESULT	Y1	Y2	Y3	Y4	Y5
Co-diagnose Barriers	1	Landscape mapping at all levels, from available data and known barriers: - Low access to health facilities - Stigma, discrimination - Unreliable data - Lack of QA system - Week supervision - Poorly managed supply chain	All					
Co-design HSS approaches	2	Local Systems Engagement	All					
	3	Health Governance	All					
	4	Human Resources for Health & Services delivery	All					
	5	Health Information	Result 1+2					
	6	Health Finance	Result 1+2					
Co-implement proven interventions	7	Mass Distribution	Result 1					
	8	Routine Distribution	Result 1					
	9	ITN durability monitoring	Result 1					
	10	SBCC	Result 2					
	11	Case Management	Result 2					
	12	ICCM	Result 2					
	13	MIP	Result 2					
	14	Case Finding, Linkages	Result 3					
	15	PMTCT	Result 3					
	16	Treatment	Result 3					
	17	Community case-management for key, priority pops	Result 3					
	18	Integrated FP/RH, MCH and HIV services, SBCC	Result 4					
	19	Contraceptive security	Result 4					
	20	Private sector engagement	Result 4					
Improve Outcomes	21	Improved Access to and use of LLIN	Result 1					
	22	Improved Malaria Services	Result 2					
	23	Sustainable continuum of care HIV/AIDS model established	Result 3					
	24	Strengthened integrated FP/RH services	Result 4					