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HEALTHFORALL

Population Services International (PSI)

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ACRONYM LIST

ACT	Artemisinin-based Combination Therapy
ADECOS	<i>Agentes de Desenvolvimento Comunitário e Sanitário</i> (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-piperazine
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
OM	Optical Microscopy
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
PNC	Prenatal care
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
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 3 (APR-JUN 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 April 1st and June 30th, 2018 (3rd Quarter of Year 2 or FY18).

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

1.1 Background

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 USAID's Procurement and Supply Management (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 completed (in FY17), while phase 3 is presently taking place and phase 4 will happen during Q2 FY19.

1.2 Targets for FY18:

As mentioned in the previous report, changes in the availability of LLINs, after the end of phase 2, (Q1 FY17), forced the targets for FY18 to be adjusted, according to the new agreement with National Malaria Control Program / National Direction of Public Health (NMCP/NDPH), the President's Malaria Initiative (PMI)/USAID and partners. The table below reflects such changes, as well as the revised targets for FY18:

Quarter	Province	Population in 2018	LLINs need	n° of households	n° of children under 5	n° of Pregnant Women
Q1 (phase 2)	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*	-	0	0	0	0	0
Q3 (phase 3)	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
Q4	Cuando Cubango	854,258	474,588	185,708	165,555	21,186
	Moxico	601,454	334,141	130,751	116,562	14,916
	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	3,037,746	1,687,637	660,379	588,715	75,336
TOTAL FY18		7,038,045	3,910,025	1,530,009	1,363,973	174,543

*No distribution happened during Q2, therefore all Q2 results are zero

** The distribution campaign in Lunda Norte and Lunda Sul will only finish during Q1 FY19 (by mid-Nov/18). Therefor the achieved results in FY18 will be smaller than proposed in the table above, which initially considered all 4 provinces of phase 3 to be completed in Q4.

1.3 Major Achievements during Q3 FY18:

After all adjustments were made and final definition on which LLINs to be used for phase 3 of the mass distribution campaign, the province of Huambo was the only province that witnessed the distribution of mosquito nets during Q3.

The table below shows the initial target for the FY18 and the achievements reached until the end of Q3. The last column of the table shows YTD achievements (Q1 + Q2 + Q3) against the modified year targets up to 30th of June 2018.

Performance Indicators	Target	Achievements FY18				Achieved YTD/ Year target
	2018	Q1	Q2*	Q3	Q4	
1. Number of insecticide treated nets (LLINs) that were distributed in this reported fiscal year	3,910,025	796,257	0	1,296,350	-	2,092,607/ 3,910,025 (53.52%)
2. Number of community Health Workers trained in counseling on LLIN-use in this reported fiscal year	4,653	931	0	1,124	-	2,055/ 4,653 (44.16%)
3. Number of households with at least one LLIN for every two people in this reported fiscal year	1,530,009	240,971	0	468,589	-	709,560/ 1,530,009 (46.38%)
4. Number of Children < 5 covered with LLIN in this reported fiscal year	1,363,973	210,488	0	386,012	-	596,500/ 1,363,973 (43.73%)
5. Number of pregnant women covered with LLIN in this reported fiscal year	174,543	45,958	0	78,289	-	124,247/ 174,543 (71.18%)

*No distribution happened during Q2, therefor all Q2 results are zero.

Indicators of LLIN Distribution, per municipality, for the province of Huambo (May-July 2018)					
	LLINs Distributed	# Households Registered	Population Registered	Children under 5 years	Pregnant Women
Caála	212,598	71,162	392,037	71,187	12,723
Londumbale	94,665	35,762	169,290	29,124	5,091
Ucuma	43,304	17,413	76,927	13,922	3,343
Ecunha	66,919	25,807	120,729	20,392	3,834
Longonjo	66,460	25,127	120,205	17,319	2,948
Chinjenje	27,976	11,703	49,387	8,237	1,335
Catchiungo	85,799	31,348	156,760	23,814	4,261
Mungo	86,396	34,137	157,699	23,822	4,930
Bailundo	196,743	73,439	355,093	51,134	13,518
Huambo	415,490	142,691	750,815	127,061	26,306
Total	1,296,350	468,589	2,348,942	386,012	78,289

1.4 Major Constraints Faced during Q3 FY18:

Like in the previous reporting period, the major constraint faced by HFA regarding LLIN distribution in Quarter 3, was the delay to determine and agree on the source (PMI procured, GF procured or MOH procured) of LLINs and the provinces to be covered.

By mid-April, the following plan was finally approved by DNSP/NMCP and its partners (PMI/USAID, Global Fund, WHO):

- Emergency mass distribution in Huambo, with LLINs from NMCP/DNSP and funding from PMI/USAID;
- Mass distribution in Cuando Cubango and Moxico provinces, with Global Fund nets and funding from PMI/USAID;
- Mass distribution in Lunda Norte and Lunda Sul provinces, with mosquito nets and funding from PMI/USAID.

1.5 Proposed Targets for Q4:

Once the LLIN mass distribution campaign was resumed, following the jointly defined plan (see item 1.4 above), activities in Huambo province started (mid-May), and expected to be completed by mid-July. HFA had to revise its targets, proposing to cover 100% of the provinces of Cuando Cubango and Moxico and partially covering Lunda Sul and Lunda Norte, until Sept 30th (distribution will end by mid-Nov/18 in these provinces passing to Q1 Y3). New targets for Cuando Cubango, Moxico, Lunda Norte and Lunda Sul, in Q4 are:

- Distribution of **1,687,637** LLINs
- Estimated population to be covered: **3,037,746** beneficiaries (**75,336** pregnant women + **588,715** children <5 years-old)
- **1,916** community health workers (HWs) (activists and field supervisors) to be trained in communication, registration, and distribution;
- New Mass Distribution Toolkit completed and submitted for approval by the MOH by the end of Q4: the toolkit is in final stages of review by PSI and USAID before being translated to Portuguese, ready to be submitted to DNSP/NMCP for their input and final approval;

1.6 Communication campaign to support LLIN distribution

In Q3, PSI has received communication from AO and AOR to de-prioritize development and implementation of SBCC activities until further decision by PMI.

Before this communication the following SBCC activities were implemented:

During Q3, the HFA communication and training team worked with NMCP to agree on a joint implementation plan, based on the existing SBCC Strategy developed by VectorWorks and NMCP in March 2017 and funded by PMI. That SBCC implementation plan aimed to promote the use of mosquito nets following LLIN mass distribution (phases 1, 2, and 3), in all 11 targeted provinces and to educate and motivate pregnant women to go for antenatal care services, at least 4 times during their pregnancy.

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

HFA SBCC communication objectives focus on achieving behavior change through the continuous and correct use of LLINs. The communication interventions to achieve behavior change take place *before*, *during*, and *after* the LLIN distribution campaign:

➤ **Communication pre and during LLIN distribution campaigns:**

Dissemination of messages in local media, followed by direct communication by activists with beneficiaries prior to and during household registration to create awareness about the LLIN distribution in the location and inform about distribution time and location. The messages (based on guidelines established by NMCP) aim to:

- Improve knowledge that LLIN nets protect against mosquito bites;
- Improve skills on how to hang nets appropriately;
- Motivate families to sleep under the nets every night, with special focus on children under 5 years of age and pregnant women;
- Discourage the use of LLINs for non-intended purposes (e.g. fishing, covering gardens, etc.), by reinforcing the message of the proper use of LLIN.

➤ **Communication post LLIN distribution campaigns:**

Continued dissemination of messages in local media and by SMS (UNITEL), together with messages disseminated by priests/pastors and other community leaders (e.g. sobas, teachers and health professionals), during religious ceremonies, community gatherings, in schools and local health facilities.

In terms of messages, HFA has been using the official and approved messages defined and approved by the NMCP.

Message dissemination considers ethnolinguistic groups in the country: IEC materials have been developed in at least one of the local languages (*Umbundu*), mostly spoken in southern Angola, representing approximately 23% of the total population. The MoH is requesting support from universities to have IEC/BCC materials also translated to other frequently used indigenous languages (e.g. *Kikongo* and *Kimbundu*).

The communication channels most commonly used to achieve the objectives mentioned above are:

- behavior change communication channels *before* the distribution of LLINs: SMS, communication activists and ADECOS (community development and sanitation agents);
- behavior change communication channels *after* the distribution of LLINs: radio jingle, leaflets, posters, SMS, flipcharts used by health workers, direct messages given by traditional leaders and ADECOS.

In summary, the following communication tools are being used:

Activity Level	Provinces
Radio Jingle played in local radio stations	6 (Zaire, Uige, Malange, Kwanza Norte, Cunene and Namibe)
Leaflets on correct use of LLIN	3 (Huambo, Cuando Cubango and Moxico)
Posters on correct use of LLIN	3 (Huambo, Cuando Cubango and Moxico)
SMS messages sent by Unitel	5 (Huambo, C. Cubango and Moxico)
Flipcharts used by traditional leaders and health workers	9 (Zaire, Uige, Malange, Kwanza Norte, Cunene, Namibe, Huambo, C. Cubango and Moxico)
Traditional Leaders trained	3 (Huambo, Cuando Cubango and Moxico)
Activists trained	3 (Huambo, Cuando Cubango and Moxico)

The communication done by the activists, traditional leaders and ADECOS is being developed as follows:

- *Activists*: each activist is recruited from within a certain community. His/Her task is to visit each household within that same specific area, before and after the LLIN distribution. Before the distribution, the main task is to register each household, collecting information about the number of people living there, informing them about the LLIN distribution activities that will soon start, the importance of the net use and how malaria can be prevented by making use of the LLIN. The number of households varies from 30 to 50, according to the number of people in each municipality.
- *Traditional Leaders*: these can include religious leaders, sobas or other individuals that are seen by a certain community as a leader, with deep knowledge and understanding of the area. Traditional leaders, based on the status they hold within the community, they are responsible for promoting regular sessions with the local population, during which they cover various subjects that are considered important to the community. The strategy is to include messages about malaria prevention among those subjects. The number of people involved in these sessions varies a lot according to population density. For the definition of the number of traditional leaders needed, HFA assumed that, for every 100 people, one traditional leader must be involved.

1.7 SBCC Achievements in Q3:

SBCC training for the mass LLIN campaign were implemented in Huambo with the following results:

Indicators	Q3 Target	Achieved	%
# of trainers of activists trained	35	35	100
# of activists trained	1,124	1,124	100
# of traditional leaders trained	50	50	100
# SMS sent by Unitel in Huambo*	N/A	369,684	N/A

* The messages sent were:

- 1- 'Durma sempre debaixo do mosquiteiro tratado com insecticida e proteja a sua família. Stop Malária.'
- 2- 'Use sempre o mosquiteiro tratado com inseticida e proteja-se da picada do mosquito. Stop Malária.'

1.8 SBCC Activities planned for Q4:

The following activities have been planned and await approval / clarification:

- Dissemination of a malaria prevention jingle in all provinces that have been targeted with LLIN mass distribution (to be used soon after the end of the distribution campaign);
- Dissemination of MIP materials to all health units that provide ANC services in the municipalities where LLIN mass distribution took place (to be used before and after the distribution campaign);
- Dissemination of leaflets and posters on malaria prevention in the provinces of Cuando Cubango and Moxico, during the LLIN mass distribution campaign.

HFA proposes to monitor post distribution communication campaign using the following indicators:

- % of people sleeping under a LLIN the night before the survey (disaggregated by target groups);
- % of people who know that LLINs protect against mosquito bites;
- % of people that were involved in a session addressing malaria messages, presented by a traditional leader;
- % of people that received a SMS message from Unitel.

1.9 Proposed SBCC targets for Q4:

Indicators	Q4 Target
# Malaria Provincial Supervisor (MPS) and Health Training Provincial Supervisor (HTPS) trained on BCC	8
# of traditional leaders trained	200
# of activists' trainers (Moxico, Cuando Cubango, Lunda Sul and Lunda Norte)	83
# of activists' supervisors (Moxico, Cuando Cubango, Lunda Sul and Lunda Norte)	206
# of activists (Moxico, Cuando Cubango, Lunda Sul and Lunda Norte)	1,710
# of TKMI/CICA volunteers as activists	57
# of people reached with Unitel messages (pre, during and post campaign) *	211,602
Local Radio spot on LLIN usage once a day, seven days a week, one month before and one month after campaign, per province – after one month of interregnum	On-going

*Number shared by Unitel, only for Moxico and Cuando Cubango.

1.10 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	468,589	-	1,264,846
# of activists trained on communicating correct LLIN use messages to the population**	931	N/A	1,124	-	2,055

* 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 implemented FY17 and FY18 activities in 24 municipalities out of 61 in the PMI provinces, it covered **78.3%** of its population.

PROVINCE	NAME OF MUNICIPALITY	% OF TOTAL POPULATION OF PROVINCE	# OF HEALTH UNITS
Cuanza Norte	Cazengo, Cambambe, Ambaca	74%	57
Lunda Norte	Lucapa, Cambulo, Chitato, Cuango	78.6%	39
Lunda Sul	Saurimo, Cacolo	88%	49
Malanje	Malanje Sede, Cacuso, Calandula Cambundi Katembo, Luquembo	81%	84
Uíge	Negage, Maquela do Zombo, Sanza Pombo, Quimbele, Puri, Uíge Sede	68%	125
Zaire	Mbanza Kongo, Soyo, Kuimba	80.5%	53
Total	24	78.3%	407

During year 3, HFA will expand its malaria activities to all 61 municipalities of the 6 PMI provinces.

2.2 Targets for FY18:

To improve the capacity of National Malaria Trainers of Trainers in “*Adult Teach Skills*”, the 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 PMI provinces. As the CENFFOR curriculum is very comprehensive (92 hours over 1 month), the first part of the training, for the first group of trainers, was conducted in April and the second one in July (see table below for details).

FORMAÇÃO PEDAGÓGICA INICIAL DE FORMADORES- 2018 Acção n°8- PNCM / CINFOTEC Talatona.					
Meses	Data	Dias	Horas	Módulos para 1º fase	Formadores
ABRIL	16	2ª feira	8	O Formador e o Contexto em que se desenvolve a	Fátima Simão
	17	3ª feira	8	Simulação Pedagógica Inicial/ Autoscopia inicial	Telma Costa
	18	4ª feira	8	Processos Facilitadores de Aquisição de Conhecimentos	Telma Costa
	19	5ª feira	8	Gestão de Percursos Diferenciados de Aprendizagem e	Hamilton de Brito
	20	6ª feira	8	Metodologias e Estratégias Pedagógicas	Domingos Antunes
	21	Sábado	4	Recursos Didáticos na Formação Profissional	Hamilton de Brito
			44H		
				Módulos para 2º fase	
JULHO	23	2ª feira	8	Definição e Estruturação dos Objectivos	Fátima Simão
	24	3ª feira	4	Temas transversais	Miguel Bango
			4	Estatística Aplicada a Formação Profissional	Miguel Bango
	25	4ª feira	8	Avaliação da Formação	Isaías João
	26	5ª feira	8	Planificação da Formação	Hamilton de Brito
	27	6ª feira	4	Planificação da Formação	Hamilton de Brito
			4	Simulação Pedagógica Final /Autoscopia Final	Hamilton de Brito
	28	Sábado	8	Simulação Pedagógica Final /Autoscopia Final	Hamilton de Brito
			48H		
		TOTAL	92H		

As mentioned in the Q2 report, the supervision tool originally developed by NMCP was identified as too long and cumbersome, and needed updating before being used during the supervision visits in Q3.

After the updating of the supervision tools (copies already submitted together with Q2 Report), supervision visits and training activities were re-planned and the targets for quarters 3 and 4 were revised as follows:

Performance Indicators	Target 2018	Quarterly targets for FY18			
		Q1	Q2	Q3	Q4
1. Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds.	1,000	0	0	300	700
2. Number of health workers trained in malaria diagnostics with rapid diagnostic tests (RDTs) with USG funds.	1,542	0	0	500	1,042
3. Number of health workers trained in malaria laboratory diagnostics (microscopy) with USG funds.	135	0	0	60	75
4. Number of health workers trained in intermittent preventive treatment in pregnancy (IPTp) with USG funds.	407	0	0	187	220
5. Number of health workers who received formative supervision on malaria diagnostic in the fiscal year.	320	90	30	50	150
6. Number of health workers who received formative supervision in ACT use in the fiscal year.	320	90	30	50	150

2.3 Major Achievements during Q3:

2.3.1 Trainings on Malaria Case Management (MCM) and Lab Diagnosis (LD)

- **Malaria Case Management:**

During this reporting period, **624** health workers (HW) were trained in malaria case management in the 6 PMI provinces (Cuanza Norte, Malanje, Lunda Sul, Lunda Norte, Uíge, and Zaire).

Medical doctors were trained through 5 training sessions of 5 days each, covering **100 doctors** (51 in Lunda Norte, 39 in Lunda Sul and 10 in Uíge). These trainings were facilitated by MoH certified trainers from national and local levels.

Nurses received training sessions of four days duration. In total, **524 nurses** were trained in malaria case management. These trainings were also facilitated by MoH certified trainers from national and local levels.

- **Malaria in Pregnancy / IPTp:**

Nurses and mid-wives responsible for Malaria in Pregnancy (MIP) received training sessions for five days. In total, **182 nurses/ midwives** that provide antenatal care (ANC) services in health units (HU) like hospitals and health centers in the periphery, were trained during Q3.

- **Training on lab diagnosis through RDT and optic microscopy**

In total, **87 Lab Technicians** were trained during a 10-day training on Laboratory Diagnosis of Malaria, through rapid diagnostic tests (RDTs) and optic microscopy (OM). The training sessions were carried out in Lunda Norte, Lunda Sul, Zaire, and Uíge. The lab technicians that were targeted came from health facilities with functional laboratories in the municipalities of those four provinces. Lab technicians from the two remaining provinces (Malanje and Cuanza Norte) will receive training during Q4.

The table below summarizes the CMC trainings that happened in Q3:

Province	Malaria Case Management	Case Management in Pregnancy / Intermittent Preventive Treatment in Pregnancy (IPTp)	Lab diagnosis by microscopy
Cuanza Norte	82	36	0
Malanje	109	42	0
Lunda Norte	100	27	13
Lunda Sul	82	21	18
Uíge	162	34	39
Zaire	89	22	17
Total	624	182	87

The table below shows the results achieved in Q3 against the proposed targets:

Performance Indicators	Target 2018	Achieved targets per Quarter				Achieved in Q1 + Q2+Q3/ Year Target
		Q1	Q2	Q3	Q4	
1. Number of HW trained in case management with artemisinin-based combination therapy (ACTs) with USG funds.	1,000	0	0	624	-	624/1,000 (62.4%)
2. Number of HW trained in malaria diagnostics with rapid diagnostic tests (RDTs) with USG funds.	1,542	0	0	893	-	893/1,542 (57.9%)
3. Number of HW trained in malaria laboratory diagnostics (microscopy only) with USG funds.	135	0	0	87	-	87/135 (64.4%)
4. Number of HW trained in intermittent preventive treatment in pregnancy (IPTp) with USG funds.	407	0	0	182	-	182/407 (44.7%)
5. Number of HW who received formative supervision on malaria diagnostic in the fiscal year.	320	85	49	92	-	226/320 (70.6%)
6. Number of HW who received formative supervision in ACT use in the fiscal year.	320	85	49	92	-	226/320 (70.6%)

2.3.2 Formative Supervisions

Methods

To assess the impact of continuous training of health workers on malaria case management, supervision activities were conducted from April to June of the current year (2018), in four provinces of Angola (Malanje, Kuanza Norte, Lunda Norte and Lunda Sul), covered by HFA project. A total of 40 health units received supervision.

Province	Total N° of Health Units
Malange	7
Kwanza Norte	16
Lunda Sul	8
Lunda Norte	9
Total N° of provincial health units	40

A survey tool developed by the NMCP was used for assessing the availability of diagnosis methods (microscopy and RDT). The scope of supervision covered the assessment of health workers knowledge and good practices for malaria case management, in 40 health units. The supervision was conducted using a checklist tool appropriated for three sections representing the health areas supervised: prenatal care, pediatrics and adult medicine; health workers at the emergency room at each of these sections, where also supervised.

In each section the checklist focused in the following aspects:

- 1) *ANC*: confirmation of the gestational age of the pregnant women, IPT administration, confirmation of malaria diagnosis (OM/RDT), adequate prescription of treatment, identification and case management of severe malaria and IEC delivery.
- 2) *Pediatrics*: confirmation of malaria symptom, recognition of severe malaria symptoms and adequate treatment care as well as IEC delivery.
- 3) *Adults medicine*: confirmation of malaria diagnosis (OM/RDT), before treatment administration, adequate treatment care of normal or severe malaria and IEC delivery.

In each province there was one supervision team composed of the following members: the provincial malaria official (OPM), the provincial official for the malaria program (OPPM) and a third member who is being trained as a supervisor.

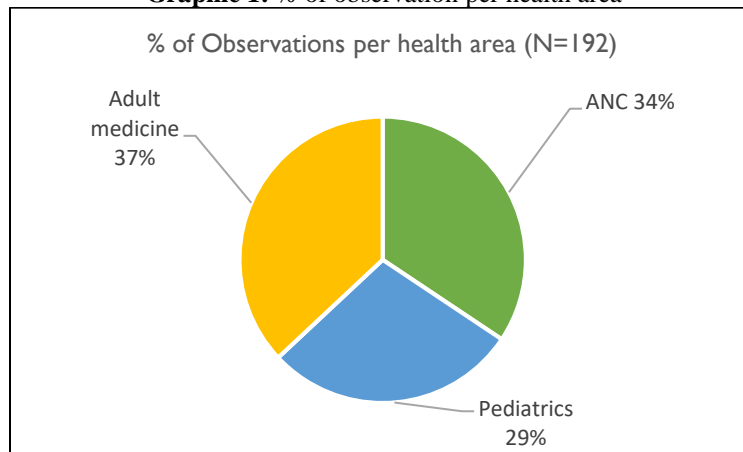
The supervision checklists were filled through direct observation of health workers providing care to suspected malaria cases. Each health worker was observed one or two times according to the number of patients available at the health unit, at the specific time of supervision.

Province	N° of health units supervised	N° of people supervised		
		Total	Female	Male
Malange	7	21	15	6
Kuanza Norte	16	31	15	16
Lunda Norte	9	26	12	14
Lunda Sul	8	14	8	6
Total	40	92	50	42

Results on Supervision: Knowledge and Good Practices on Malaria Case Management

Results showed that a total of 92 health workers were supervised through direct observation, on their knowledge and good practices on malaria case management. Since each health worker was supervised one or two times on average, a total of 192 observations were conducted, out of which 34% at antenatal care (ANC), 29% at pediatrics and 37% at adult medicine (see graphic 1).

Graphic 1: % of observation per health area



In total, 192 observations were registered whereas 34% at ANC, 29% at pediatrics and 37% at the adult medicine.

The sections that scored less in each area, and therefore need most improvement, are the following (see Annex 1 - Supervision Results: Assessment of health workers knowledge and good practices on malaria case management) for a full list of items evaluated with respective score):

- a) 66 observations at ANC and emergency room with pregnant women:
 - Administration of 1° dose of SP if the gestational age is equal or superior to 13 weeks or if, the pregnant woman regularly feels fetal movements (scored 78%);
 - If the pregnant woman is taking IPT with SP, the nurse should reduce folic acid to <5 mg/day- (scored 76,9%);
 - If the pregnant woman is seropositive, while taking cotrimoxazol, she should not take SP (scored 64,9%);
 - If the nurse provides first aid services to a pregnant woman (SOS immobilization, provides artesunate rectal formula, intravenous diazepam) and transfer the woman to a reference hospital (scored 72,9%).

In ANC, health workers have scored 100% in confirmation of pregnancy and assessing vital signs.

- b) 55 observations in pediatric and emergency room with children:
 - Ask the mother/father if the children had any difficulties in eating or if it has been vomiting after eating (scored 69,4%);
 - Verifies signals of respiratory difficulty (scored 65,3%);
 - Search for signs of stiff neck, bulging fontanelle and other signs of danger (scored 71,4%);
 - Provides one LLIN or gives information regarding where the mother/father can have access to LLIN and provide advise on how to use it every night (scored 75,0%).

In pediatrics, the best score was 96,1%, regarding the prescription of Coarten, ASAQ or Duo-Cotecxin, if RDT is positive and the child does not present emergency signs.

- c) 71 observations in the medicine and emergency room with adults:
 - Discard other diseases that can present the same symptoms and signs of malaria (scored 75%);

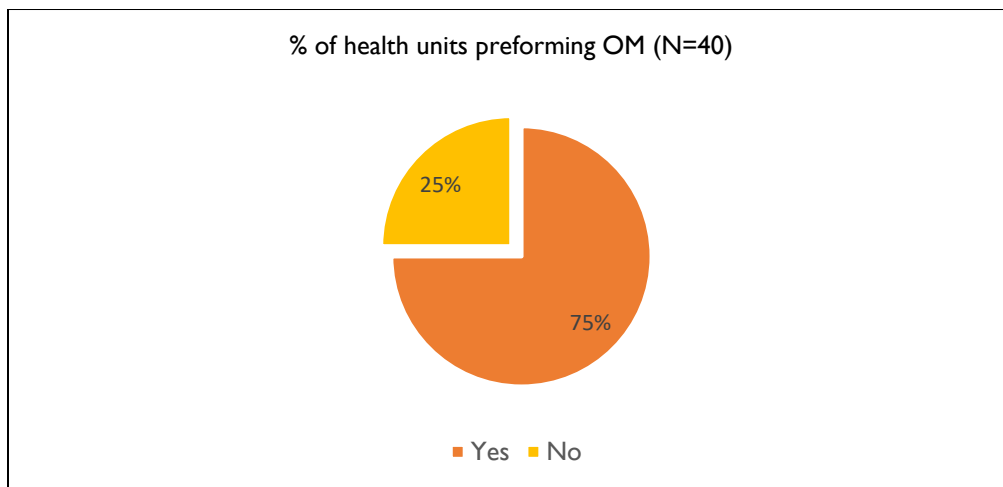
- In case of a malaria suspected case, performs RDT and/or asks for the plasmodium smear and provides correct interpretation of results (scored 83,8%);
- If the RDT result is negative and there is still suspicion of a positive case, the health worker asks for a plasmodium smear and conducts a new evaluation in search of other diseases (differential diagnosis) (scored 76,5%);
- If the health worker provides information on measures for malaria prevention (scored 73,8%).

In adult medicine, health workers best scored was of 97,1% in the assessment of malaria symptoms or other fever diseases.

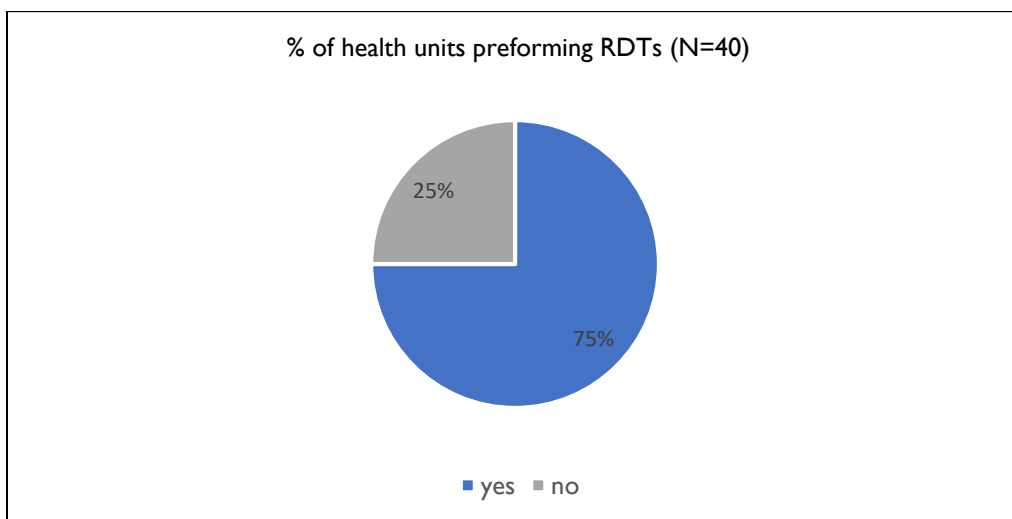
Results on Supervision: Health Units Using Microscopy and RDTs

Results from the supervision show that OM and RDT diagnosis are equally preformed (75%) in health units covered by HFA project.

Graphic 2: % of Health Units performing optical microscopy



Graphic 3: % of Health Units performing Optical microscopy



Discussion & Recommendation based on Supervision Results:

Overall, the supervision results showed a positive result of the continuous training of health workers on malaria case management in the four provinces covered by HFA project.

Further trainings of health workers should emphasize sections where health workers have scored less. For example:

- *In ANC*: If the pregnant woman is seropositive, while taking cotrimoxazol, she should not take SP (Scored 64,9 %);
- *In pediatrics*: verifies signals of respiratory difficulty (scored 65,3%);
- *In adult medicine*: if the RDT result is negative and there is still suspicion of a positive case, the health worker asks for a plasmodium smear and conducts a new evaluation in search of other diseases (differential diagnosis) (scored 76,5%); (See supervision checklist in annex – Annex 1).

2.3.3 Monitoring of Lab Technicians trained in RDT and OM:

Monitoring and supervision visits to HU that had at least one lab technician trained in malaria diagnosis using RDTs and microscopy, took place between June 27th and 30th in the provinces of Lunda Sul (16 technicians), Kwanza Norte (25 technicians), Zaire (16 technicians) Malanje (21 technicians), with a total number of 78 technicians trained. The visits aimed to observe and evaluate the capacity of the trained lab technicians to correctly diagnose malaria. The disposal of toxic residues was also observed in all health units visited during this period.

The following findings were registered, and appropriate recommendations left at each HU, with responsible local supervisors:

- There is frequent lack of running water and the electric current oscillated dangerously, which can compromise the lab equipment.
- There is frequent stockout of consumables and reagents in general, especially for OM, the cited reason being the lack of an internal distribution plan for consumables.
- In the provinces of Lunda Norte and Lunda Sul, there is new equipment available that is not being used because of either a lack of reagents (either stockout or expired stock) or they were never assembled by the supplier. If this is the situation, soon the equipment will become inoperable.
- There are no visible guidelines for the correct disposal of hospital residues, like separation of toxic materials in appropriate containers (cartons or pet bottles) and use of regular plastic bags for common garbage. All toxic material is later incinerated outside the HU.

Additionally, the NMCP standard tool for supervision of health workers, although good in assessing step by step details on malaria case management, does not contain detailed items on OM and RDT technique performance. Therefore, we recommend the addition of a more detailed section on the checklist assessing technical performance of OM and RDT.

2.3.4 Implementation of iCCM (ADECOS) during Q3:

A national Technical Working Group (TWG) already exists to oversee the iCCM activities. Current members include the Global Fund, principal recipient World Vision International (WVI), UNICEF, WHO, MOH, FAS, IFAL, HFA and USAID. The last meeting with all TWG members was held on the 3rd of April 2018.

iCCM activities in the six WVI pilot provinces, have been ongoing for over one year now and the ADECOS are already working in their communities. An overall evaluation was implemented by UNICEF in six active provinces. The results of the evaluation will be soon shared with all partners/stakeholders. The evaluation will serve as guidance for the development and implementation of iCCM's activities in the next stages of expansion to remaining provinces in Angola.

The training of ADECOS in the two provinces under the responsibility of HFA (Lunda Sul and Zaire) was the main activity done during the reporting period. The training was conducted in two phases, due to constraints related to the software application (KoboCollect), that was supposed to be installed and configured in the mobile phones to be provided to all ADECOS and in the computers to be provided to their supervisors. FAS and World Vision have not yet come to an agreement regarding the use of that software with provinces outside the scope of work of WV.

Since all ADECOS had already been selected by FAS and all materials and equipment have been duly procured by HFA, it was decided to have the first phase of training of ADECOS in April and complete the training once the software had been adapted and configured for use in both provinces.

HFA, in close coordination with the NMCP and FAS, organized and implemented the training of ADECOS in both provinces, Lunda Sul and Zaire. During the implementation of the trainings, NMCP, FAS, IFAL, PSI and the Malaria provincial teams (OPMs, OPPMs, SPPMs) were providing support to the ADECOS Trainers (Supervisors).

- In Zaire, the first phase of the training of ADECOS took place between April 23rd and May 5th in the municipalities of Soyo and Tomboco, while the second phase happened between the 18th and the 21st of June. The field activities have not yet started, since the contracts with the 60 ADECOS (30 in Tomboco and 30 in Soyo) have not yet been signed with FAS.
- In Lunda Sul, the training of ADECOS started on April 25th and ended on May 7th. Similarly, field activities have not yet started in Lunda Sul, since the contracts with the 60 ADECOS (30 in Dala and 30 in Cacolo) have not yet been signed with FAS.

The second phase of the training went ahead in June in both provinces, despite not solving the issue regarding the software KoboCollect. The second phase of training focused on the use of the “family notebooks”, where all information is recorded during each visit to families by the ADECOS.

In the meantime, a wide dissemination of information through the local press and a formal presentation of the ADECOS project to traditional leaders and the community in general happened during the event that celebrated the closure of the first phase of trainings in each municipality, either on June 20th or 21st.

2.4 Major Constraints Faced during Q3:

a. Malaria Case Management: Inconsistent supply of ACTs and RDTs

During the assessment visits to HUs in the six PMI provinces and supervision visits in Zaire, 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 Uncomplicated (simple) and Complicated (severe) Malaria, was not being appropriately followed. For some patients, for example, simple malaria cases were being treated with severe malaria treatment regimens, also supposedly 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.

b. Malaria in Pregnancy (MIP): Inconsistent supply of IPTp (SP) makes demand creation and adherence to ANC visits challenging

During supervision visits to HU that provide ANC services, a common situation was observed regarding the use of SP: frequent stockouts. Most HU informed visiting supervisors that ANC services have been prescribing SP (following the national protocol) 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.

Recommendations for Remaining of FY18:

- ❖ **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 complicated malaria treatment in children, when being transferred to referral units. HW receive training on the use of RAS as part of the malaria case management training being provided;
 - Forms for data collection to be regularly distributed to all health facilities. The municipal focal point sends to the SPPM a requisition with the needs for the forms (e.g. malaria monthly statistical report sheets, registration forms, etc.). To improve the M&E system, the provincial malaria team, including the SPPM, OPM, OPPM, SSR Focal Point, must become responsible for printing and distributing the necessary forms to the HU in need. The quantity of each form can be estimated to cover the needs of at least a quarter.
- ❖ **NMCP to continue providing training and supporting formative supervision** of service providers, especially for the HUs with improved supervision reports. The MOH has been sending recently graduated service providers with a low level of knowledge/capacity to the provinces.
 - To expand the training actions to non-target municipalities in all six PMI provinces, the NMCP and partners should give the opportunity to all malaria trainers to attend the training on “adult teaching skills”, provided by CENFFOR. The second phase of the first training of 41 trainers will happen in July 23rd to 28th, funded by USAID through HFA. Other similar trainings should be replicated during FY19 with the coordination with partners as GF and WHO.
 - HFA, in coordination with NMCP and DPS, will distribute manuals and protocols related to malaria case management to all health facilities, and lab diagnosis manuals to all health facilities with laboratory. Furthermore, HFA intends to organize trainings of all staff responsible for statistic in the hospitals to align and familiarize themselves with the reporting system used by the NMCP, especially with the use of report sheets.
- ❖ **DPS to improve frequency and quality of reporting to NMCP**, with support from the OPMs, by using a standardized model of monthly malaria report sent to NMCP at the end of each month. HFA will support NMCP to improve the model of monthly malaria report to be submitted by each DPS (SPPM), aiming at presenting progress of planned activities during the month.
 - The OPMs will also submit monthly reports to the central level (HFA) summarizing activities implemented, meetings held with DPS, DMS, and other partners, results achieved on trainings, supervisions, sharing constraints and proposed solutions, and proposing the activity plan of the following month.
 - A regular two-day meeting between OPMs and the M&E team will be organized in Luanda to discuss about the type of reports and standardization of reports and databases of trainings and supervisions.
- ❖ **HFA to develop additional data collection tool to yield more qualitative information about supervision and monitoring visits:** The HFA Malaria Technical Team is presently developing two instruments to help OPMs yield more qualitative information regarding HWs supervised and health facilities visited. These tools include:
 - a **Health Facilities Visited Sheet:** The HFVS provides summarized information like name and type of health facility (HF), number of health facilities visited during a given time-period, which ones have malaria protocols and manuals on case management, which ones are experiencing stockouts of RDTs, ACTs, SP and other antimalarial, as well as what actions are to be taken by the supervision team.
 - a **HW Supervised Sheet:** The HWSS yields information about the HW supervised like his/her name, gender, his/her professional category, in what health facility and service area he/she works, how knowledgeable and skillful he/she is on referrals, prescription of ACTs, ANC/IPTs, and actions taken for no compliance of malaria protocols.

Both easy-to-use instruments will be tested by M&E team during data processing from the supervision guides already sent by team staffs in the field. The assumption is that the tools will be presented and discussed with NMCP in the coming month of August and, once approved, it would be an added value to the existing supervision guide that was recently updated.

- ❖ **NMCP and HFA to hold quarterly coordination & evaluation meetings** on implementation of malaria activities at provincial level. NMCP and HFA should hold regular 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 can support the Provincial Malaria Team to develop and present the epidemiological situation, achievements during the last quarter, and plans for the following period.
 - OPMs are sending to the central level (Luanda) the information on malaria epidemiological situation of the HFA targeted and non-targeted municipalities of the six PMI provinces. The HFA Technical Team and M&E team will analyze the data and the findings will be presented together with the Q4 FY2018 report.
- ❖ **PMI to advocate with MOH for better coordination of the implementation and expansion of iCCM strategy**
 - **Share ADECOS reporting with DPS:** Based on the outcomes of meetings with FAS, World Vision, NMCP, and GEPE/ GTI that happened during Q3, to analyze the possibility of linking SIBM and DHIS2, and to ensure the harmonization of ADECOS activities among different partners, HFA's M&E team attended the trainings of ADECOS in Soyo and Tomboco/Zaire for a better understanding of how the ADECOS and supervisors collect and analyze data - physically with the "family notebooks/forms" and through KoboCollect. PSI will work to find an interoperability solution to link information collected through KoboCollect with DHIS2.
 - **Regarding the start of field activities:** HFA supply team has been working at a fast pace to procure all materials and equipment and make sure that all needed materials and equipment are received by the representative of FAS in both provinces. PSI will write a letter of donation to be signed by FAS. USAID/PMI might play a role to speed up the signing of contracts between municipal administrations and the ADECOS. At the same time FAS, IFAL, PSI, and Mentor will schedule meetings to discuss and align with the municipal administrations to start with the ADECOS activities in Q4.

2.5 Proposed Targets for Q4:

In Q4, HFA will keep focusing on 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 Q4 FY18			
Province	# of existing health facilities (HF)	# of HW targeted for training*	# of lab technicians targeted for training*
Malanje	84	139	27
Lunda Norte	39	8	0
Lunda Sul	49	66	0
Cuanza Norte	57	79	18
Zaire	53	72	1
Uige	125	237	2
TOTAL	407	601	48

* Overall targets were calculated by subtracting achievements in Q1-Q3 from annual target by province. The program might readjust the proposed target based on cost-effectiveness of logistics: when values are very small in one province (1-10 HW to be trained, for example) it might be better to move those targets to another province.

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

HFA Result 2 – Formative Supervision Targets for 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	25	1
Lunda Norte	39	0	0
Lunda Sul	49	12	9
Cuanza Norte	57	5	0
Zaire	53	0	0
Uige	125	52	20
TOTAL	407	94	30

* Overall targets were calculated by subtracting achievements in Q1-Q3 from annual target by province. The program might readjust the proposed target based on cost-effectiveness of logistics: when values are very small in one province (1-10 HW to be supervised, for example) it might be better to move those targets to another province.

**Annual targets used to calculate Q4 targets were re-adjusted considering the number of of HW trained in Q1-Q3 and those expected to be trained in Q4.

Since the basic conditions for implementing trainings and formative supervisions have been created, through training TOTs in “adult teaching skills” (CENFFOR) and updating and segregating supervision tools, the key activities to be implemented in the last quarter (Q4) will be to:

- Provide the second phase of training on “adult teaching skills” to malaria TOTs (CENFFOR);
- Implement the updated training and supervision plans for 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);

➤ **Implementation of activities related to iCCM in 4 municipalities of Lunda Sul and Zaire:**

During the following quarter, HFA will prioritize the following points (resume in the table below):

- Initiation of uncomplicated malaria management activities in the community by ADECOS - July to September.
- Training of ADECOS on the information management application using smartphones – August.
- Training and supervision of referral HU that provide support to ADECOS on malaria case management – August.
- Supervision of ADECOS on patient data management, ASAQ and TDRs records of patients assisted by ADECOS and patients referenced to HU - August to September.
- Monthly exchange of experience between supervisors and ADECOS - August-September
- Monitoring the work of the ADECOS through the supervisors and partners involved
- Strongly advocate with the referral HU in relation to the follow-up of the stock of medicines (ACTs) and RDTs
- Visit families registered in each micro area and area of coverage, according to the schedule prepared by local supervisors
- Give feedback of the first month of activities to the municipal health administrations according to report elaborated by FAS.

<i>QUARTER 4 FY18</i>	July				August				September			
	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	X	X	X
Training of Lab Tech on Lab diagnosis by microscopy	X	X				X	X			X	X	
Training of HWs 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
National coordination & evaluation meeting with provincial teams												X
iCCM activities												
Training of ADECOS in Lunda Sul and Zaire						X			X			
Training of ADECOS in the use of smartphones with the app for data collection							X	X				
Implementation of uncomplicated malaria case management of children under 5 years of age by ADECOS	X	X	X	X	X	X	X	X	X	X	X	X
Supervision of ADECOS in their micro-areas on data collected and registries of patients assisted, and patients referred to HU	X	X	X	X	X	X	X	X	X	X	X	X
Training on malaria case management of HW from the Health Facilities located near the micro areas of ADECOS (reference points)				X	X	X	X					

2.6 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	N/A	N/A	-	0
# of TOTs trained on lab waste management	N/A	N/A	N/A	-	0
# of HW trained in waste management	0	0	893	-	893
# of ADECOS trained in waste management	N/A**	N/A**	60	-	60

* In Q2 HFA initiated conversations with NMCP to see if there was any existing instrument to assess facilities. The MOH does not have any such instrument, so HFA developed 1 tool based on USAID's 2015 Sector Environmental Guidelines for Health Care Waste. The assessment of HF based on that tool will take place during Q4;

** The ADECOS component of HFA has not yet started

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

3.1 Background:

HFA's program goal is to have *USAID Angola partnerships transformed to strengthen the effective use of Angola's resources to meet the country's development needs*. Management Sciences for Health (MSH) is a part of the HFA consortium, led by Population Services International (PSI) with responsibility for establishing a sustainable model for providing high-quality HIV/AIDS services.

3.2 Summary of Major Achievements in Q3:

During Q3 of FY18, MSH continued working in close collaboration with its key stakeholders, including the National Institute to Fight HIV/AIDS in Angola (INLS). Other stakeholders include the Cabinet of Provincial Health 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 Procurement Supply Management (PSM). During Q3, in cooperation with these partners, MSH was able to accomplish the following:

- Assumed full responsibility for M&E, including data collection and analysis within the seven Health Facilities (HFs) located in the province of Luanda;
- Continued improving in the collection and analysis of data across the seven HFs through daily supervision, after MSH assumed management responsibility for M&E staff from PSI (eight data clerks and one coordinator); the senior M&E advisor is now in charge of the staff and data quality control;
- Patient Assistant Facilitators (PAFs) under HFA continued with weekly supervisory visits and close follow-up in the different services at the HFs, which led to improved efficiency whereby HFA contributed to the reduction in the wait time between testing, getting the result and counseling to no more than one hour;

- Improved the control of stock management at the facility level and strengthened collaboration with the supply chain project (PSM/MSH monthly meeting) through permanent supervision and reporting, which included concise but comprehensive information;
- Shortened the transition period of patients from pre-antiretroviral treatment (pre-ART) to ART, through monitoring and linkage to treatment;
- Continued to improve patient retention and adherence to treatment through PAF support and personal follow-up with the patients and worked with PAFs to create a new tool (Defaulters Form) that collects these data;
- Created a new tool to collect data on HIV positive patient follow-up to know the causes of lost to follow-up (LTFU), increase the number of patients on ART and improve adherence;
- The *Dispensario* Anti-TB health facility stopped implementing the One-Stop Shop strategy and started focusing exclusively on specific services for HIV/TB co-infected patients every tuesday and friday;
- Ensured adherence to norms and protocols for quality improvement developed by MINSA and INLS, through the CMs and PAFs doing quality improvement activities;
- Provided technical assistance and training to carry out quality improvement activities in the HFs through daily supervision by case managers.

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

Figure 1. Results and Targets for FY18/QR3 across the Clinical Cascade

Results & Targets for FY2018/Q3 Across the Clinical Cascade				
INDICATORS	ANNUAL TARGET 2018	TARGET Q3	RESULTS Q3	RESULTS AGAINST TARGET Q3
1 HTS_TST	43,845	10,962	19,006	173.4%
2 HTS_TST_POS	5,843	1,461	1,558	106.6%
3 TX_NEW	7,543	1,886	990	52.5%
4 TX_CURR	22,003	22,003	20,640	93.8%

Figure 2. Results of Q1, Q2, and Q3 (FY18) Compared with Annual Targets

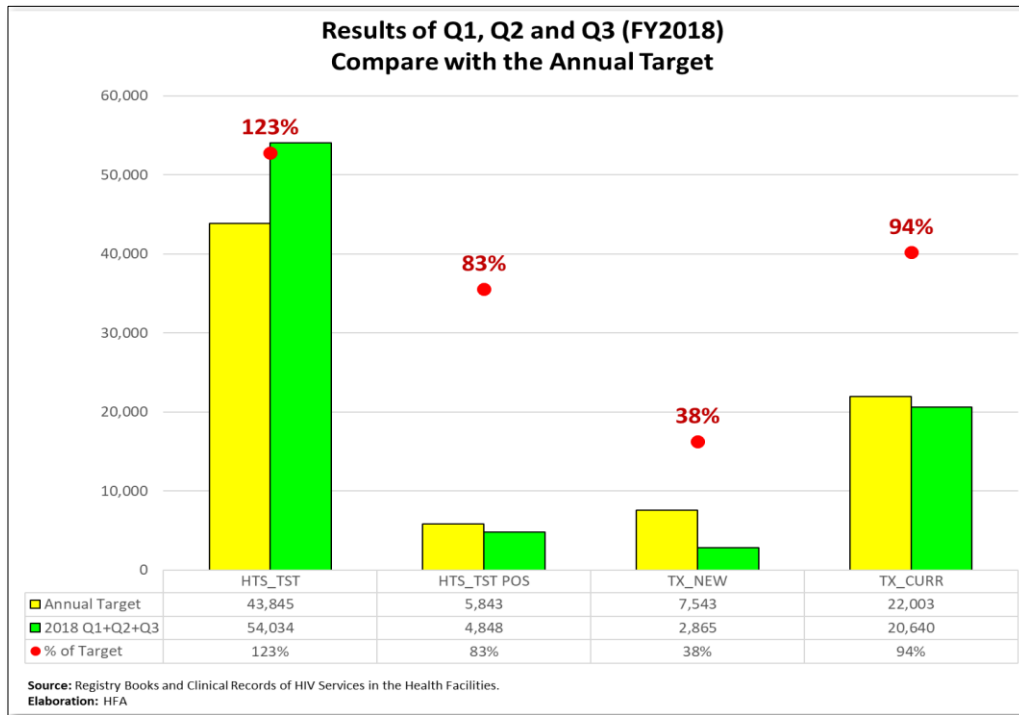


Figure 3. Percentage of Achievements of Testing (HTS_TST) by Health Facility Compared with the Annual Targets for Q1, Q2, and Q3 (FY18)

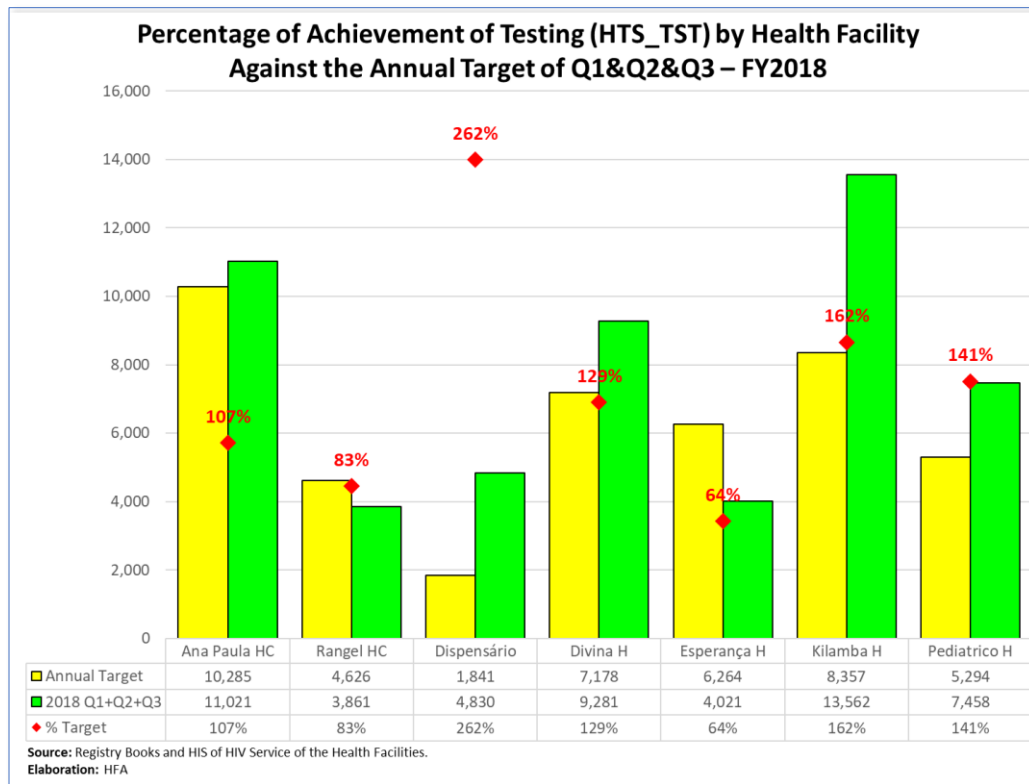


Figure 4. Percentage of Achievement of TX_New by HF Compared with the Annual Targets for Q1, Q2, and Q3 (FY18)

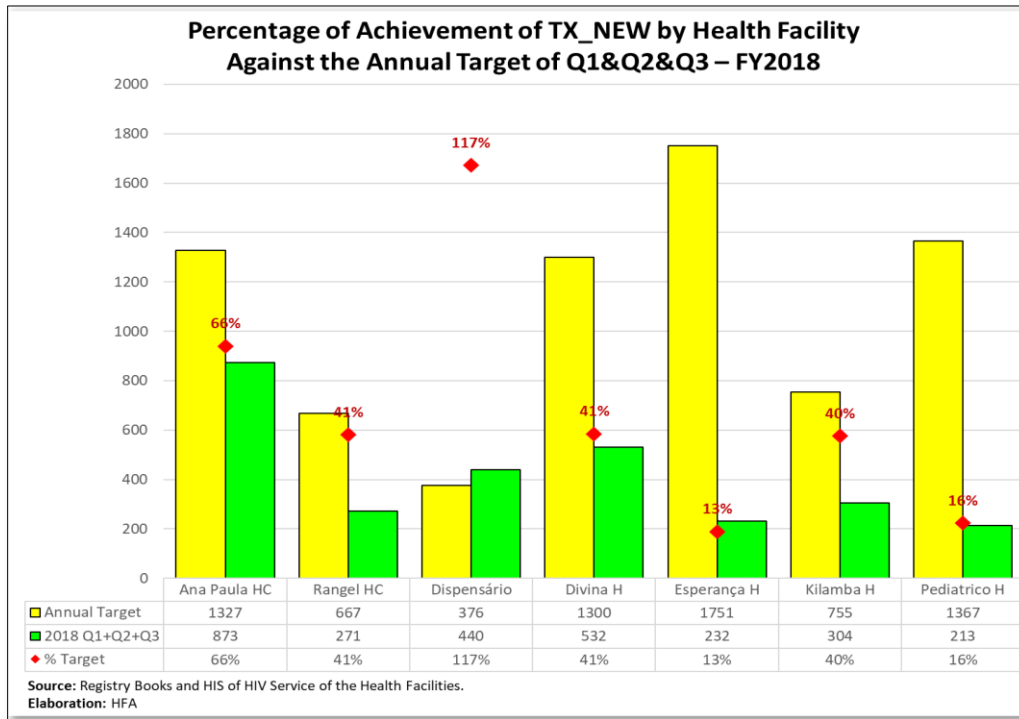
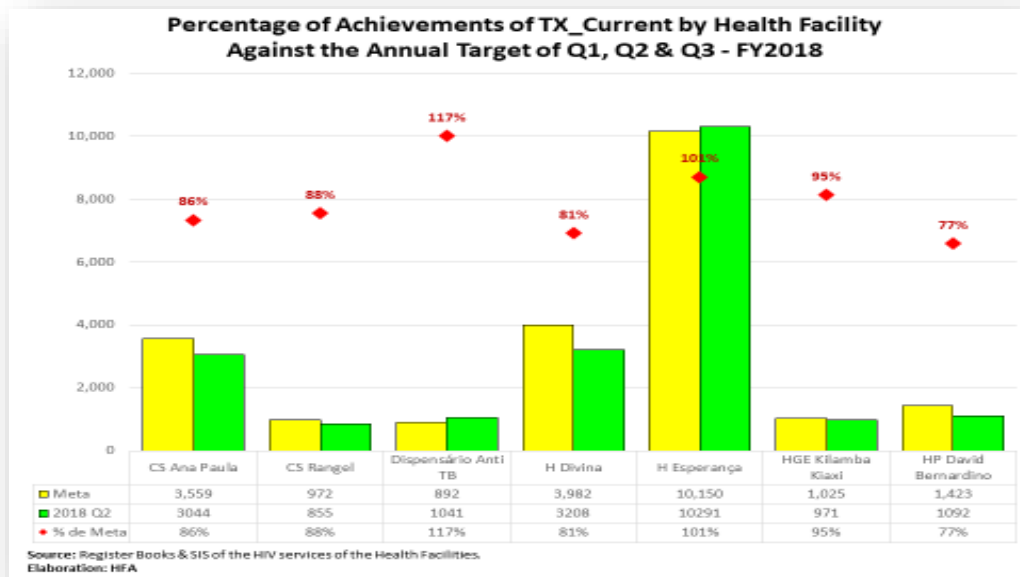


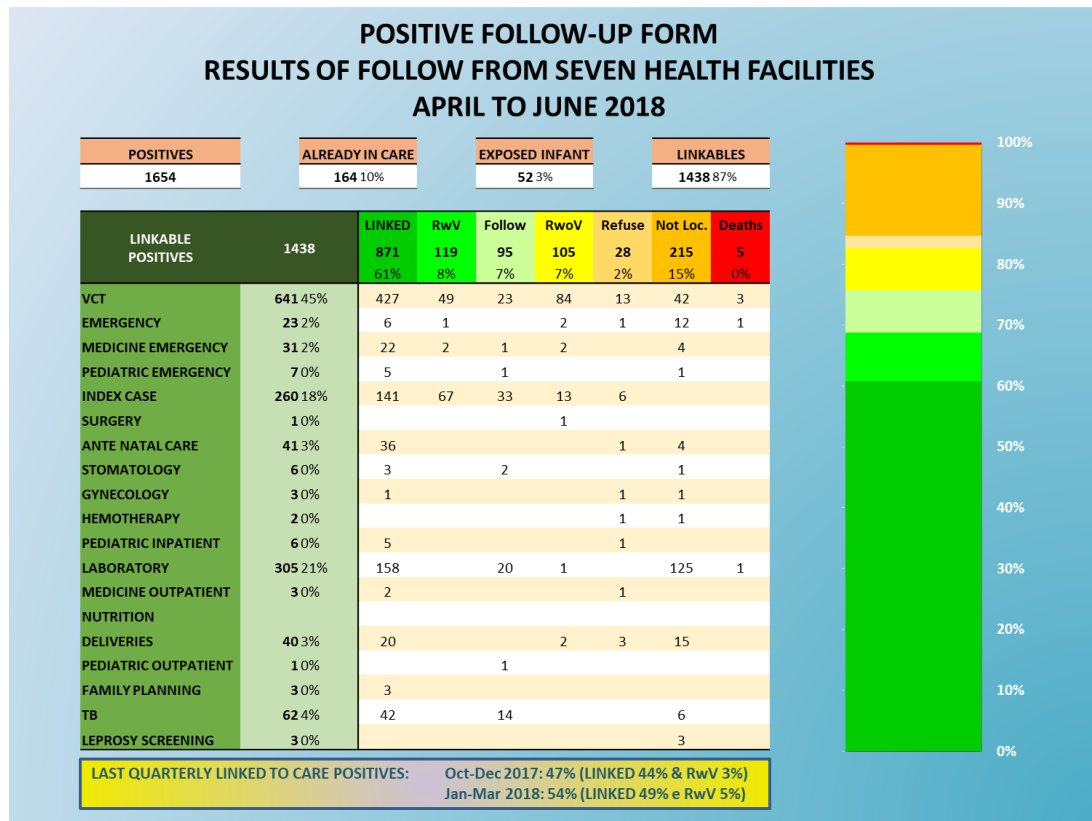
Figure 5. Percentage of Achievement of TX_Current by HF Compared with the Annual Targets for Q1, Q2, and Q3 (FY18)



3.2.1 Brief Narrative on Results by Indicator:

1. **HTS_TST:** During Q3 FY18, the project reached **19,006** individuals with HTS. This achievement represents **173.4%** of the target for Q3 (**10,962**) and largely reflects the success of the project’s key testing strategies, including:
 - a. The allocation of several testing points in each HU and permanent quality control of them;
 - b. Provision of collective and individual counseling through PAFs;
 - c. Deployment of the Index Case Tracing and Testing (ICTT) strategy;
 - d. Supportive supervision to guarantee improvements in the quality of the implementation of testing activities and data capture in the health register.
2. **HTS_TST_POS:** During Q3 FY18, **1,558** new positive cases were identified through the project. This achievement represents **106.6%** of the target for Q3 (1,461). The achievement is mainly due to the project’s key testing strategies, including the ICTT strategy, which produced a 29% yield, and the focus of the PAFs, CCs, and CMs on testing and screening of high-risk people based on personal reports of behavior.
3. **TX_NEW:** During Q3 FY18, there were **990** new registered cases on ART. This achievement represents **52.5%** of the Q3 target for Q3 (1,886). Progress against the annual target for FY18 is still suboptimal given the overall 25% achievement against the target of 7,543 cases. HFA plans to reinforce the strategy and support the HFs in supervising all testing points to ensure linkages during the first consult to initiate ART immediately through CMs and PAFs.
4. **TX_CURR:** There were **20,640** patients on treatment during Q3 FY18, representing **93.8%** of the FY18 target (22,003).

Figure 6: Follow up of the HIV Positive Cases in the Seven HFs from April to June 2018 (Q3)



NEW TOOL: Figure 6 shows the data collection on follow-up for HIV positive patients after being tested. The indicator TX_NEW is still suboptimal, and the main challenge is to link positive cases to ART. To tackle the issue, HFA implemented this new tool to identify the causes for LTFU and focus on these causes to increase the number of HIV positive patients linked to ART and improve adherence.

The total number of positive patients in this quarter was of 1,654, but we did not consider the 164 (10%) already in care and children under 18 months because they are only exposed infants. The total number of patients linkable to care is 1,438. Of those, 871 (61%) were linked to care, 119 (8%) were routed with verification (RwV), 95 (7%) were being followed, 105 (7%) were routed without verification (RwoV), 28 (~2%) refused care, 215 (15%) were not located and 5 (0.3%) had died.

The main conclusions are that the total number of patients linked to ART is 990 (69%) (Green Area), and 215 (15%) patients were lost (Not Located). We must further analyze the causes for this 15% of HIV positive patients lost to follow-up and recover as many as possible.

Figure 7: Defaulters register by PAF during the Q3 from April to June 2018

Period	Defaulters	Recovered	Not Located	Deaths	Refuses	Self-Transferred
April	1,630	756	848	10	11	5
May	1,600	949	635	5	5	3
June	1,540	663	864	5	5	3
Total Q3	4,770	2,368	2,347	20	21	11
Percentage	100%	49.64%	49.20%	0.42%	0.44%	0.23%

Source: PAF's Book Register from Health Facilities. Elaboration: HFA.

3.3 Summary of Key Interventions during Q3:

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 of the responsibility of International Center for AIDS Care and Treatment Program (ICAP).

The number of facility staff trained by the HFA Project was 280. This number is the total staff planned to be trained in the seven HFs during the Q3. Trainings were conducted on the following topics:

TRAINING		
<i>Themes</i>	<i>Health Facility</i>	<i>Number of Staff who participated</i>
<ul style="list-style-type: none"> • Refresher training on the diagnosis and clinical management of children living with HIV in 1 HF; 	Pediatrico Hospital	78
<ul style="list-style-type: none"> • Feedback and updating of the main M & E indicators reported to PEPFAR in 6 HFs; 	Esperança, Dispensario, K.Kiaxi, Rangel and Pediatrico	48
<ul style="list-style-type: none"> • Clinical training for requesting and interpreting GeneXpert results in 5HFs; 	Viana, Dispensario, K.Kiaxi, Esperanca and Rangel	93
<ul style="list-style-type: none"> • Virus Load monitoring and training of HIV-positive patients in 4 HFs. 	Dispensario, K.Kiaxi and Rangel	61
Total	7 Health Facilities	280

The senior HIV adviser and the PAFs/CCs coordinator supervised all staff providing HIV services.

The supervision included:

SUPERVISION		
<i>Activity</i>	<i>Health Facilities Involved</i>	<i>Staff involved in Supervision</i>
• Supervision/mentoring for nurses at HIV testing points	7 HF's	9
• Supervision/mentoring for technicians (HIV focal points and clinicians) responsible for care of co-infected patients	7 HF's	7
• Supervision/mentoring for technicians (HIV focal points and clinicians) working in HIV services	7 HF's	7
• Supervision of the active search conducted by PAFs of the patients who abandon treatment	7 HF's	12
• Supervision of the ICTT strategy implementation conducted by Case Managers and the Responsible Coordinator of these activities	6 HF's (Esperanca has not implemented ICTT)	--
TOTAL	7 HF's	35

Figure 8. IR 3: Sustainable Model Providing High-Quality HIV/AIDS Services: Q1, Q2, and Q3, FY18

IR 3: Sustainable Model Providing High-Quality HIV/AIDS Services Q1-Q2-Q3 FY18			
Indicators	Achieved		
	Q1	Q2	Q3
1. Number of SOPs revised/developed to improve standards for HIV care and treatment in nine PEPFAR facilities	Responsibility of ICAP	Responsibility of ICAP	Responsibility of ICAP
2. Number of staff trained at Facility level by HFA on the use of SOPs for HIV/AIDS services	70	195	280 *
3. Number of trained staff supervised by HFA on the use of SOPs for HIV/AIDS services	37	48	35 *

*Staff trained and supervised who have received theoretical and practical training on the disposal of medical and laboratory materials. For the training, HFA is following the “GUIA DE GESTÃO DE RESÍDUOS HOSPITALARES E DE SERVIÇOS DE SAÚDE” (Management Guidelines for Hospitals and Health Centers waste) from the Ministry of Health of Angola (2015).

3.3.2 Index Case Testing & Tracing

During the reporting period, HFA was successful in continuing to improve the ICTT strategy due to the excellent work done by HFA’s community counsellors and the strong coordination with HF staff, including PAFs and CMs supported by the HFA Project.

Figure 9. Index Case, Contacts, Positives, and Linked to Care by Health Facility: Q3 FY18

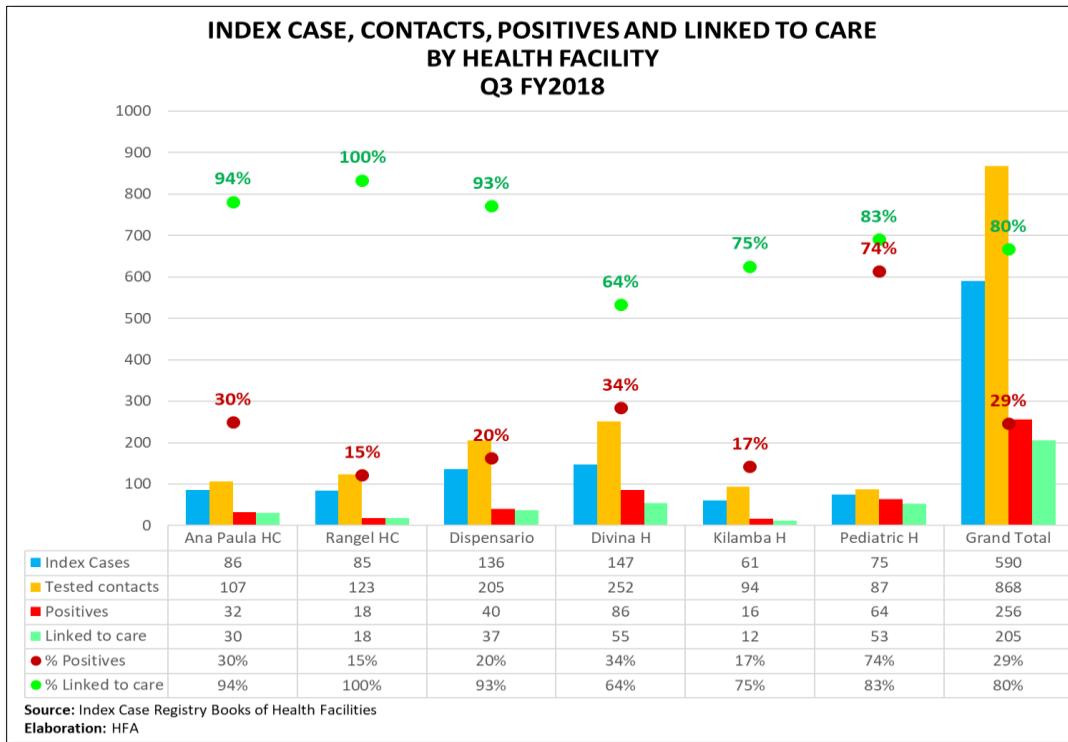
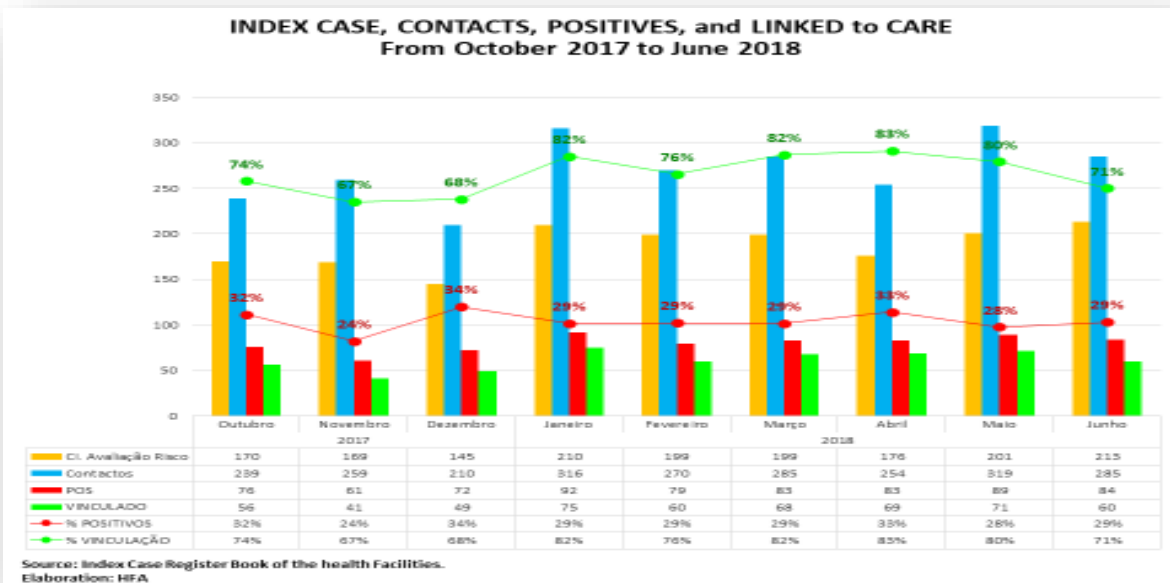


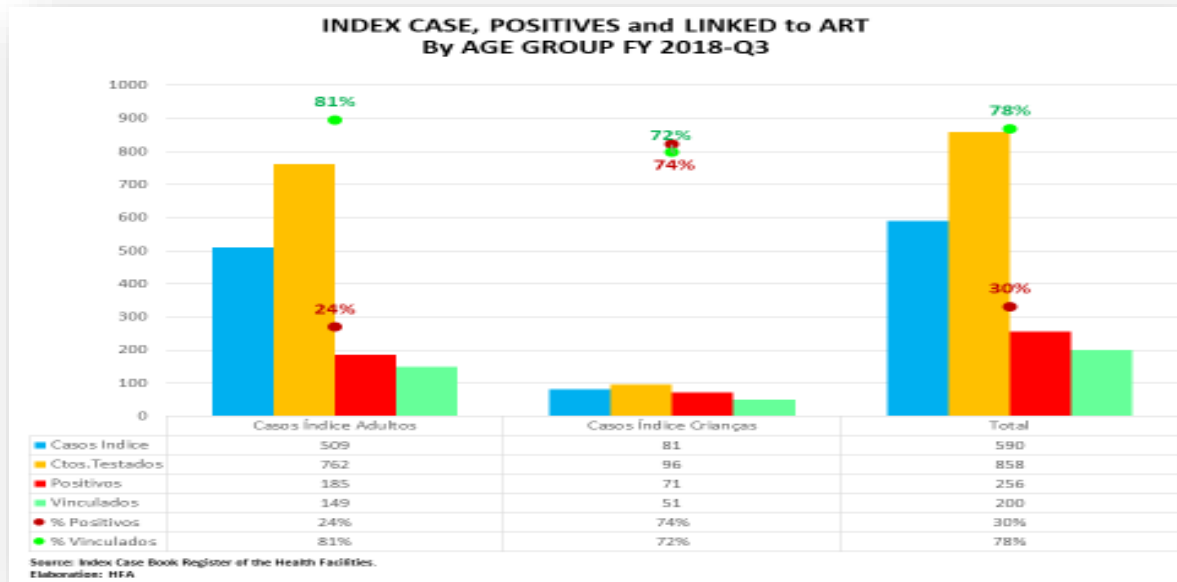
Figure 9 presents the number of index cases (blue) and contacts tested (orange), as well as the percentage of positive cases (red) identified among contacts by facility. The more important point is the high percentage of positives (red dot) with an average of 29% and the high percentage of the positives linked to treatment (green dot) with an average of 80%.

Figure 10. Index Case, Contacts, Positives, and Linked to Care, October 2017–June 2018



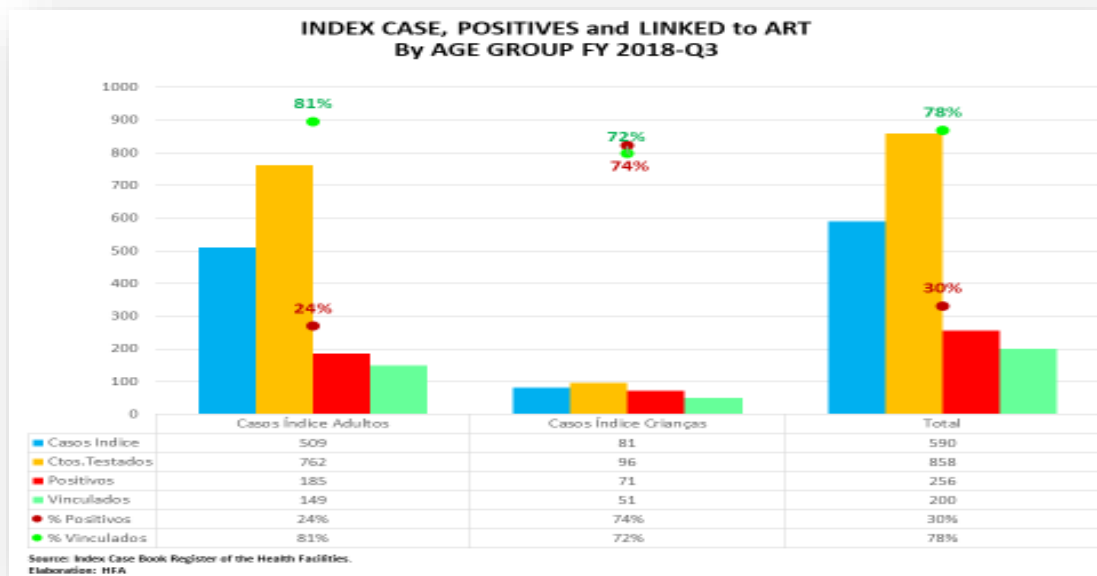
This figure shows the regularity of the Index Case results from October 2017 to June 2018 with a significant percentage of positive patients and a high percentage of those linked to ART.

Figure 11: Index Case, Positives and Linked to Treatment by Age Group



This figure shows the regularity of the Index Case results from October 2017 to June 2018 with a significant percentage of positive patients and a high percentage of those linked to ART.

Figure 11: Index Case, Positives and Linked to Treatment by Age Group



This figure shows the positive cases identified and linked to treatment by age group: adults >15 years and children <15 years old.

3.4 Major Constraints and Solutions during Q3:

- **Viral Load (VL) Suppression:** The installation of equipment is completed but the provision of basic supplies (especially micro-tubes and EDTA tubs) are dependent on the GPSL (MOH) and they have had challenges with regularly providing the supplies. After training was conducted by the INLS, AFENET, and HFA in the HFs of Viana, Kilamba Kiaxi, Rangel, and *Dispensário*, our seven HFs began sending VL samples to their respective laboratories: Esperança, Divina, and Pediátrico to LBM (INLS) and Viana, Rangel, Kilamba Kiaxi and *Dispensario* to LMC.
- One constraint was the **transport of the samples**, but during this period, the INIS (National Research Institute for Health) made an agreement with the INLS and AFENET to regularly transport all samples from the nine PEPFAR-assigned health facilities.
- Another constraint was **patient absenteeism**. However HFA used a requisition form to collect the samples for VL testing on the day of the consultation for patients who met the requirements for the VL test in the four HFs that send samples to LMC. This activity increased the number of VL tests. In addition, HFA is providing daily supervision through CMs and PAFs to interpret results of VL testing and actively search for patients who have been in ART for more than six months but have not received the VL test.
- At the end of the third quarter, our main constraint was the **follow-up of patients** with a VL test result higher than 1,000 copies/ml, which means that we must consider or suspect therapeutic failure (pharmacokinetic or tolerance reasons) when ART administered to the patient for six months does not control the HIV infection. As a result, virologic failure (>1,000 copies/ml), immunological failure (diminish CD4) and clinical failure (WHO clinical states) can occur, together or isolated. Following the criteria of the national guidelines, the last-resort decision is to change from first-line to second-line ART, which is a decision made by the ART Institutional Committee and managed by a medical doctor.
- Because of issues mentioned previously, during the next quarter HFA will **strengthen collaboration** with the INLS, AFENET, and DPSL to improve the follow up of these patients (VL test >1,000 copies/ml) and their second-line ART. This includes registration (data collection), reinforced adherence, human resources (medical doctors), medicaments availability, access to VL testing, training on second-line ART, and logistic provision.

Figure 12. Viral Load Suppression in the Seven HFs

**VIRAL LOAD SUPPRESSION IN THE SEVEN HFS
FROM OCTOBER 2017 UNTIL JUNE 2018**

Facility	FY18 Target	Register Results Oct.2017-June 2018	Percent of Target Achieved	Percentage of Patients Virally Suppressed	Estimated No. of Patients needing VL before October 2018
Rangel	479	130	27%	80%	747
Viana	1,635	386	24%	65%	2,864
Dispensario	437	49	11%	76%	943
Divina	1,973	1,839	93%	84%	3,066
Esperança	5,947	6,547	110%	72%	10,074
Kilamba Klaxi	495	209	42%	74%	866
Pediatrico	547	607	111%	44%	1,090

AFENET – Data Collected by Facility Lab VL Log Book
In the 7 HFA HF's approximately need around 20,000 VL Test until September 30th 2018.

- ART Adherence and Retention: Ensuring patient adherence to ART and retention is another challenge. HFA implemented the following activities to accelerate progress and identify patients who are lost to follow up:
 - ✓ Implemented active search by PAFs on the same day a patient misses his or her appointment and ensured that registration is initiated (figure 7);
 - ✓ Ensured active search by PAFs in coordination with HIV focal points to identify self-transfer patients and deaths and ensured that registration is initiated (figure 7);
 - ✓ Collaborated with the Prevention Department of Information, Education and Communication (DPIEC) of the INLS to improve implementation of national guidelines on adherence and retention. HFA has delivered three presentations to DPIEC on adherence and retention to be used for training in the HFs. We are waiting for the INLS director to approve this training.
- Shift of Hospital Esperança to a National Referral Hospital (School and Specialized Hospital in HIV/AIDS for complicated cases): HFA will continue working in this hospital, but we have presented a new proposal to redirect the activities to be carried out. The proposal includes the following activities:
 - ✓ Educational discussions on HIV prevention and care;
 - ✓ Linkages to the care and treatment of newly diagnosed and transferred patients;
 - ✓ Active search of patients lost to follow up;

- ✓ Active search of patients with VL >1,000 copies/ml;
- ✓ Adhesion and reinforced adhesion;
- ✓ Support of GAMs (support groups);
- ✓ Support the integration of co-infected TB/HIV patients;
- ✓ Reinforce the main indicators of the activities realized within the hospital.

3.5 Action Plan for Quarter 4 (July–September 2018):

Activities	July				August				September			
	1w	2w	3w	4w	1w	2w	3w	4w	1w	2w	3w	4w
Refreshment in HTC for HIV and linkage of the <i>positive</i> cases in the 6 HFes				X	X							
Refreshment in tracking and syndromic diagnosis on ITD according to the technical note from the INLS (April 2018) into the 7 HFes											X	X
Refreshment on tracking of TB cases and prophylaxis indication with isoniazid into the 7 HFes							X	X				
Training on identification and management of therapeutic failure into the 6 HFes									X	X		
Refreshment on analysis of the M&E main indicators into the 7 HFes						X	X					
Preparation of the Assessment Protocols		X			X	X	X	X				
Refreshment on reinforcing adhesion for PAFs, CCs, and Civil Society Organizations									X			
Training on reinforcing adhesion for professional health staff (CMs, medical doctors, nurses, and psychologists)											X	
Training on informatics system (M&N technicians, data clerks, and statisticians) into the 7 HFes							X	X	X			
Integrated supervision among INLS, PNCT, GPSL, INIS, and HFA into the 7 HFes			X	X			X	X			X	X

3.6 Environmental Mitigation Monitoring Plan FY18:

IR 3: Sustainable Model Providing High-Quality HIV/AIDS Services Q1-Q2-Q3 FY18			
Indicators	Achieved		
	Q1	Q2	Q3
1. Number of SOPs revised/developed to improve standards for HIV care and treatment in nine PEPFAR facilities	Responsibility of ICAP	Responsibility of ICAP	Responsibility of ICAP
2. Number of staff trained at Facility level by HFA on the use of SOPs for HIV/AIDS services	70	195	280 *
3. Number of trained staff supervised by HFA on the use of SOPs for HIV/AIDS services	37	48	35 *

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

4.1 Background

During the second quarter of the FY18, HFA supported activities such as increasing supportive supervision at all USG-assisted service delivery points (SDPs) offering Family Planning/Reproductive Health (FP/RH) counseling or services in Luanda, strengthening advocacy with Ministry of Health (MoH) and partners by promoting the FP2020 initiative and maintaining the Technical Working Group for Sexual and Reproductive Health (TWGSRH).

Throughout the third quarter of the FY18, besides the continuous supportive supervision, support was also given to develop new sexual and reproductive health strategy, to conduct trainings for family planning healthcare professionals in Huambo.

4.2 Targets for FY18:

In quarter three, activities were mainly related to:

- Provide refresher trainings to municipal FP supervisors in Huambo province.
- Provide advocacy training for sexual and reproductive health to women from parliamentary groups.
- Support the data collection for the National Strategy for Reproductive Health, Maternal and Child Health and Nutrition in health units in Luanda province.

The last column of the table below shows the targets achieved in Q1 + Q2 +Q3 towards the year performance indicators:

Performance Indicators	FY16 Baseline (PSI Survey/ DHS/ SASH)	Targets for 2018	Quarter targets for FY18				Achieved in Q1+Q3/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	67.9 ⁺
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	2.1% ⁺
3. Couple years protection in USG supported programs.	59,054	59,054	14,764	14,764	14,764	14,764	(96.8%) 57,190 / 59,054
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 ²
5. Number of health care workers who successfully completed an in/service training program.	192	280	50	95	95	40	45/280 (16%)
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) ³	400 (non-health worker)	30	150	150	70	188/400 ⁴ (47%)
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 ⁵	0	0	30/30 (100%)

4.3 Major Achievements during Q3:

➤ Strengthen Advocacy with MoH and Partners

In cooperation with the Provincial Department of Health (PHD) of Luanda, PSI and National Department of Public Health (DNSP) organized a meeting to present HFA project to all the municipal health directors. Besides PSI, MSH and Rede Mulher Angola (RMA - Angolan Women's Network) were present. The main objective of this meeting was to inform the municipal health directors of:

- The support of HFA to the MoH in Angola;
- FP activities (supportive supervision and SBCC) taking places at municipal level;
- HIV activities in selected health units.

¹ Non-Applicable. This indicator cannot be divided in quarters because it depends on external factor.

⁺ These values are not cumulative (it is not the sum of Q1, Q2 and Q3). They reflect the point in time, the measurement is made: for example, while during one quarter all health units could experience not stock out, the following quarter they all can experience it (or vice-versa).

² This information was not measured in Q2. It will be measured in Q4.

³ Initially it was not defined who the people trained in this category would be. In FY17 it was decided that would be non-healthcare professionals such as: activists, civil society groups, etc.

⁴ This number represent the people trained by PSI and RMA. It was added the achievements from Q1-Q3 from both RMA and PSI.

This meeting that was conducted by Dra. Regina, from PDH of Luanda and Dr. João Luz from National Department of Public Health (NDPH), allowed an environment of discussion among PHD Luanda, NDPH, municipal health directors and HFA implementors. Municipal health directors showed great interest in cooperating with HFA project and requested a deeper involvement at municipal level.

- Advocacy for Sexual and Reproductive Health – Luanda

A training on advocacy for sexual and reproductive health was conducted with 17 women from Parliamentarian groups. The objectives of this training were:

1. Provide participants with the knowledge, skills and tools that will enable them to advocate for gender equity and equality, reproductive health and rights.
2. Empower participants to design and include reproductive health programs in their workplan/political agenda.
3. Establish and build links, networks and coalitions with other civil society organizations to work more effectively for social change.

Dr. João Luz presented a topic on Women and Reproductive Health in Angola, where statistical data about fertility rate in urban and rural areas, maternal mortality rate, and teen pregnancy rates were shared. Besides that, other content regarding gender integration and advocacy tools was also given. While discussing gender integration, participants had the opportunity to discuss and share different implications for women and men of any planned policy activities, including legislation and programs, in all areas and levels. At the end of the training, each group of women wrote a draft of an advocacy plan to address issues that affects women's health. Among the 5 parliamentarian groups represented, two of the groups proposed to advocate for the reduction of teen pregnancy. The other three groups suggested to advocate for reduction of maternal mortality, lack of hospitals in rural areas and literacy rate. A follow up meeting will be held on September to understand the evolution of the proposed activities and discuss a possible action plan.

➤ **Build partnership with the leadership:**

NDPH – Department of Reproductive Health

Dr. Mansitambi João Luz was appointed by the Minister of Health to be the coordinator of the family planning in the reproductive health department at NDPH. To involve more the stakeholders, a meeting with Dr. João Luz took place to discuss the proposed FP activities. The main objectives of the meeting were: (1) to have a strong administrative support from NDPH /MoH; (2) understand MoH priorities regarding FP; and (3) to integrate HFA's FP activities with the MoH activities. As a result of the cooperation with Dr. João Luz, the following activities took place:

- Weekly work session between FP project manager from PSI/Angola and Dr. Luz at NDPH to accelerate the implementation of the current workplan.
- A meeting with GPSL (Provincial Health Department of Luanda) and all the municipal directors to present HFA's FPI activities took place.
- The training plan for Luanda and Huambo provinces were proposed before each of the provincial health departments. In Huambo, the training took place in Q3, but in Luanda the training will take place in Q4 due to other trainings scheduled with partners.

➤ **Strengthen Advocacy with the Ministry of Family, Social Affairs and Women Promotion (MASFAMU) towards Gender Based Violence**

The International Visitor Leadership Program (IVLP) was a unique opportunity for countries from developing world to reflect, learn and apply the recommendations of the Gender Based Violence Exchange Program that took place in the United States of America. Therefore, taking advantage of the partnership

between RMA and MASFAMU, one candidate from MASFAMU and another from RMA attended this meeting.

➤ **Trainings**

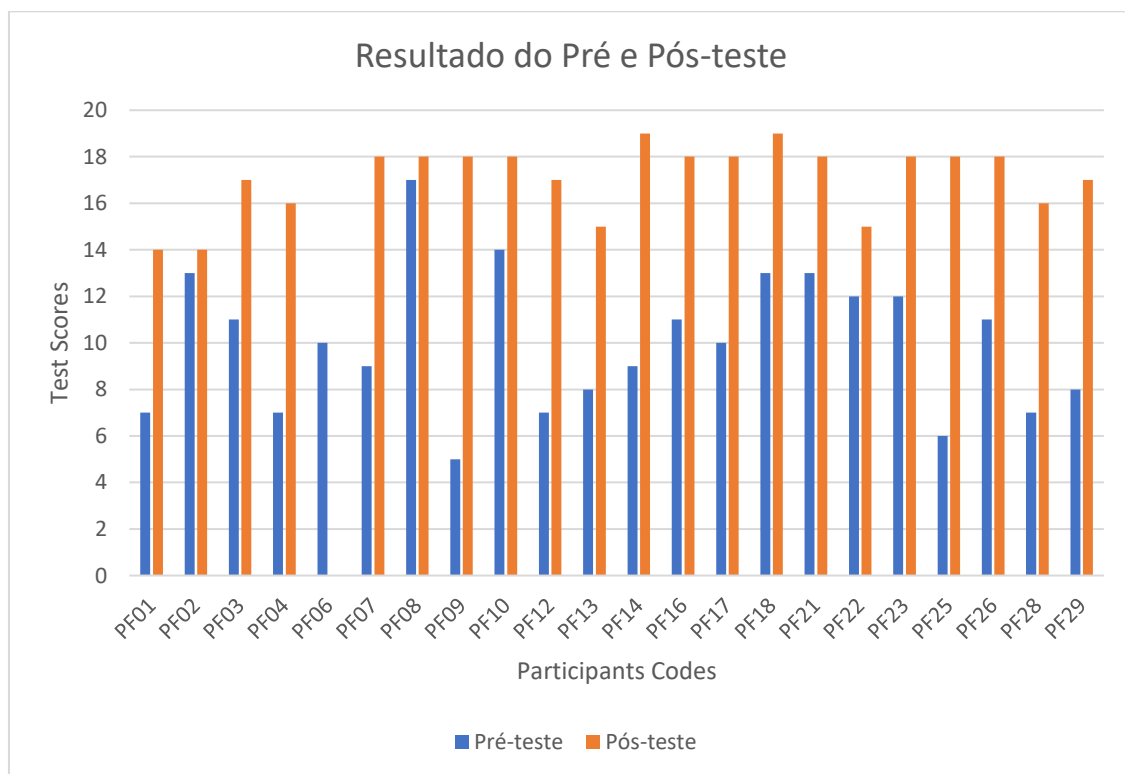
• Family Planning Municipal Focal Points and FP providers– Huambo

During June 11 to 15, a refresher training was conducted with FP municipal focal points and other FP providers from the biggest hospitals in Huambo. The focal points are responsible for the supervision, on job training and statistics of the FP services for a municipality. There is only one focal point per municipality. In total, 22 FP healthcare providers attended the training. The training curriculum followed the FP Training Manual of Trainers. However, contents such as Youth Friendly Health Services, Gender integration and Statistics were added. The objectives of the trainings were:

- To strengthen the capacity of the existing municipal FP focal points to provide better SRH/FP services to women, men, adolescents and youth.
- To better manage the logistic and statistical data about FP methods at health facility and the municipal level.
- To improve the quality of FP services at municipal levels.

To evaluate trainee’s knowledge of FP, a pre and post-test was conducted in the beginning and at the end of the training, respectively. In general, there was an increase of knowledge from the pre to post-test. The graphic below presents the summary of the pre and post-test.

Graphic 1: Pre and post-test results. Each participant was assigned a code to maintain anonymity.



Comparing pre and post-test, it was noticed that in the pre-test, 45,5% of the trainees scored less than 10 points. The lowest score in pre-test was 5 points out of 20. However, in the post test there was not any trainee that scored less than 10 points. The lowest score at post-test was 14 points out of 20. The

table below shows the main differences between pre and post-tests by comparing the percentage of positive scores (≥ 10 points); percentage of negative scores (<10 points); lowest and maximum score in pre and post-test.

Most of the providers lost points in the test because they did not have information about new guidelines in family planning, which is called MIESG (Ideal Moment and Healthy Spacing of Pregnancy). Some providers did not know about the importance of youth friendly health service and eligibility criteria for long acting reversible contraception for youth. Most of providers used had a false perception that IUD, implants, and Depo-Provera are not contraceptives suitable for adolescents and youth; especially if they do not have children yet. To overcome that misconception, the national guideline was shared, as well as the updated medical eligibility criteria produced by WHO in 2015. To ensure compliance with the national guideline, supportive supervision will focus on issues where providers showed deficiencies in knowledge.

Designation	Pre-Test	Post-Test
Number of Participants	22	21 ⁶
Percentage positive scores (≥ 10 points)	54,5%	100%
Percentage of negative scores (<10 points)	45,5%	0%
Lowest score	5	14
Maximum Score	17	19

- Refresher Training – FP Activists (RMA)

To maintain knowledge over time, all 30 FP activists participated on refresher training on FP. These two days refresher training did not only included FP but also included youth friendly health services and gender integration. Participants were informed about the current sociodemographic situation of the country (contraceptive rate, fertility rates and percentage of users by methods) to understand the current reproductive health situation.

Each of the contraceptive methods was discussed to provide the more updated information about contraceptive usage in certain circumstances. For example, contraception for adolescents and for women who not have children were discussed. Participants also received information regarding the new medical eligibility criteria determined by WHO (2015).

Furthermore, activists received information about the gender integration and the continuum of gender. Activists were encouraged to discuss gender power and dynamics with clients during group counseling sessions.

- **Gender integration**

To promote behavior change among FP healthcare providers to offer non-judgmental and client centered FP counselling, the topic of gender integration was included in the FP training in Huambo Province. In this regard, topics such as: *gender norms, power dynamics, gender and health outcomes, women empowerment and behavior change towards contraception and gender continuum* were discussed among FP providers during the trainings. In Huambo province, for instance, FP healthcare providers declared that traditional culture and religion are the main factors underlining the gender inequalities between man and woman in that province. According to the cultural beliefs, men are the providers for the families, therefore, they are the ones who have the right to take decisions about the number of children and the usage of contraception. In summary, discussions around these topics made participants reflect on the implications of the gender norms and healthcare outcomes. During a values exploration exercise, it was noticed that female healthcare providers who were above 50 years of age were less susceptible to believe that gender norms could be

⁶ One of the participants did not complete the post-test due to a test in the university.

changed; therefore, according to their point of view, men will always have the last word about contraception use and the size of the family. On the other hand, younger healthcare providers believed that responsibilities on contraception and the size of the family must be shared between men and women. Community education should be held with youth and men to promote gender equality.

➤ **Improved Supportive Supervision**

Continuous supportive supervision is being offered at USG assisted health units in Luanda and Huambo provinces. During supportive supervision, quality assurance (QA) officers (two in Luanda and one in Huambo) collect statistic and provide technical assistance to the FP providers in their health units. The table below summarizes the findings from supportive supervision by municipalities in Luanda and Huambo provinces.

Supportive supervision Summary - LUANDA			
#	Municipality	Nº of health units visited	Findings
1	Belas	6	The injectable (Depo-provera) is the most distributed method. IUDs and implants are also distributed in smaller quantities. However, Implants have more adherence than IUDs.
2	Cacuaco	15	The injectable is by far the most distributed contraceptive method in all health units in Cacuaco. Other methods, such as oral combined contraceptive (COC) pills (Microgynon), condoms, IUD and implants are distributed in very smaller quantities. It was noticed a stock out of the Emergency contraceptive (EC) pill.
3	Cazenga	2	It was found that most of the health units had four or more contraceptives available for distribution (COC, POP, injectables, implants and IUDs). Injectables are the most used contraceptive method. Between the long-term contraceptives, implants are more used than IUDs. Some of the health units have stock out of condoms and EC.
4	Icolo e Bengo	1	COC, injectables and male condoms are practically the only methods available. There is a stock out of methods such as: emergency contraceptives and IUDs.
5	Kialamba-Kiaxi	6	A good contraceptive mix across the health units was found. The injectable (Depo-provera), Microlut, Microgynon and male condoms are the most distributed methods. Although in smaller quantities, IUD and implants are also being inserted.
6	Luanda	17	Most of the health units had four or more contraceptives (COC, injectables, implants, IUDs and male condoms). As other municipalities Injectables are the most used method. Nevertheless, the number of IUDs and implants inserted are higher than other municipalities. Between the long-term contraceptives, implants are more used than IUDs.
7	Talatona	9	Injectables is the most distributed method. IUDs and implants are also distributed in smaller quantities.
8	Viana	10	The injectable (Depo-provera) is the most distributed contraceptive method followed by oral COC and oral progestogen-only contraceptive (Microlut). Few health units insert long acting reversible contraceptives (IUD and Implants).
9	Quiçama	1	In this municipality only two health units offer family planning services due to the lack of training and equipment. Depo-provera and COC are the most distributed methods.
	Total	67	

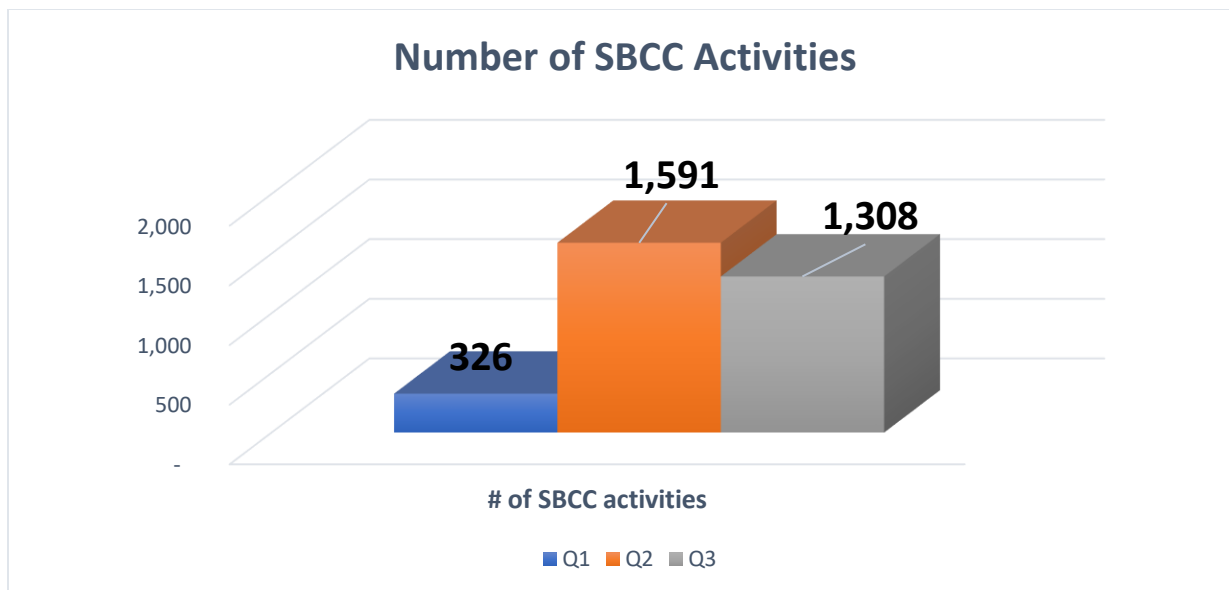
Supportive supervision Summary – Huambo			
#	Municipality	N° of health units visited	Findings
1	Bailundo	7	It is hard do access because the roads are in poor conditions. Some of the health units are not offering FP services due to the lack of contraceptives.
2	Ecunha	4	There is a severe lack of stock in Ecunha. FP services are given, but women have to buy contraceptives outside the health units.
3	Huambo	16	In this municipality, a good contraceptive mix was found. Contraceptives like IUD, implants, and oral contraceptive pills (Microlut, Microgynon and Meuri ⁷). Only few health units in Huambo were facing a stock out of contraceptives and lack of insertion material for LARCs.
4	Chicala Chiloanga	4	Most of the health units do not have FP methods. In Some health units the services are closed until the contraceptives are given to the health units.
5	Chipipa	2	Some contraceptives like Depo-Provera and oral contraceptive were found at the moment of the supervision. However, the stock was very low
6	Cáala	2	Many of the FP rooms do not insert IUDs and implants due to lack of equipment such as gynecological bed and insertion materials. Some hospitals do not have its own FP room. Services are being offered in the same room as Ante-natal care, or even at emergency room.
7	Longoanjo	2	Family planning services are inactive due to the stock out of contraceptive methods.
8	Catchiungo	2	In This municipality only 1 health unit offers family planning services. The main health unit offers a diverse methods of family planning. Although there were a good range of contraceptive methods (Depo-Provera, IUDs, Implants and oral contraceptive pills), the stock level was lower than what is needed.
	Total	39	

Based on the information collected on supportive supervision from Luanda and Huambo, HFA will advocate before DNSP, PSM and other partners to create better distribution plans to avoid stock out. In addition, all the partners will work together to influence the MoH to include contraceptives has one of the main health products in its 2019 budget. Regarding the lack of skills, HFA will help PHD in Huambo and in Luanda to conduct trainings at municipal levels.

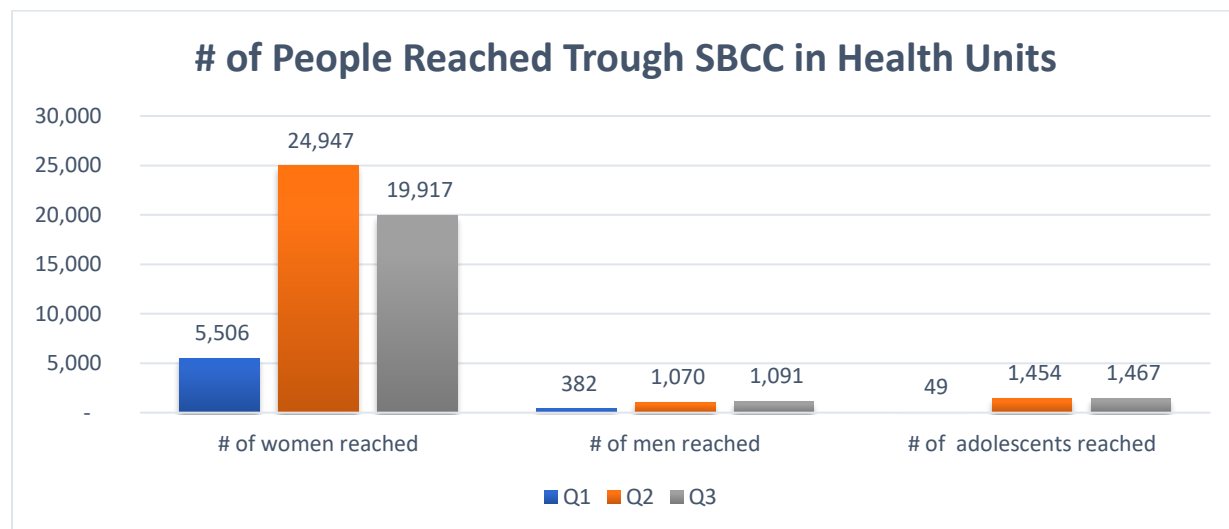
➤ **SBCC Activities**

The activists conducted SBCC activities in 63 of the health units in Luanda. The activists join the nurses of the health center for a group session in waiting room or child immunization area with all the clients. The group session that last from 10 to 15 minutes, activists give a brief description of all the contraceptive methods offered in public sector health units and then there is some time for questions and answers. After that, activists conduct another session with a smaller group of clients who are interested in knowing more about family planning. In case that clients express a desire of using a contraceptive method they are directed to the FP room where individual counseling and FP services are provided. During Q3, Activists were able to provide 1,308 sessions. The graphic below shows the number of SBCC divided by quarter.

⁷ Meuri it is a third-generation oral contraceptive pill (28 days) that was introduced in Angola in 2017. Few months ago, UNITEL donated this contraceptive to Huambo and Luanda



In Q3, activists reached the total number of 22,475 people, where most of these were women (ages 20-49). Men and adolescents (14-19) represent a small percentage of the people reached. The table below, shows the number of people reached by quarters. To reach more adolescents activities it is proposed to shift the SBCC activities from health centers to schools and youth groups. Next quarter, contacts will be made with Ministry of Youth (MINJUD) and the Ministry of Education. Working in collaboration with these two ministries will help the program to reach youth easily and prepare activities to promote behavior change and safer choices among youth.



4.4 Major Constraints Faced during Q2 FY18:

In the third quarter of the FY18, the major constraints were:

- Lack of appropriate transportation to reach difficult areas where some health units are located, especially during dry season, in Huambo and Luanda provinces (Icolo e Bengo and Quiçama

municipalities). In Huambo, in particular, it is very difficult to reach some of the health units because rental cars do not want to drive to certain areas due to the distance and poor road conditions.

- Limited stock of contraceptives in most of the health units in Huambo: this situation limits women's choice and opportunity to prevent unwanted pregnancies.
- Insufficient equipment to insert long acting reversible contraceptives (IUD and Implants) such as: insertion kits for IUD, appropriate sterilization equipment and gynecological bed in health units in Luanda and Huambo.
- Lack of material IEC in several health units in Luanda and Huambo is limiting SBCC activities.
- Lack of coordination between partners implementing similar activities, for example, HFA FP training coincided with PASS II training in Huambo. Such circumstances affected the cascade training in Huambo because the same focal points that would train providers in their municipalities had to attend another training provided by PASS II.
- Facilitation fees are one of the major constraints during trainings. National trainers, who are government employees, are used to receive monetary compensations per each day of the training, which goes against USAID regulations. Because other donors are paying facilitation fees to public sector healthcare providers and personnel to conduct trainings, HFA is finding barriers to conducting the trainings.
- SBCC strategy was not yet finalized. Therefore, it cannot be printed or disseminated. The delay in finalizing the SBCC is holding back several communication activities including the overall communication campaign. Several efforts were made to move forward, but no actual action was taken by the responsible of the department who need to approve the final version.

4.5 Recommendations for Q4 FY18:

- Acquire at least one vehicle in Huambo and other in Luanda to facilitate the supportive supervision visits even in remote areas. Transportation will also facilitate the joint supervision with NDPH and Luanda.
- Higher level advocacy is needed to encourage the MOH to buy contraceptives for the country. An adequate quantification is needed to improve the forecast of the needs.
- MOH should work jointly with PHD at provincial levels and NGOs to understand the current needs of each health unit to provide adequate equipment and consumables.
- NDPH, PHD, and partners should share their calendar of activities to coordinate activities and avoid duplication and/or coincidence of activities, such as trainings, in the same dates.
- Higher level intervention is needed to solve the problem of facilitation fees for public health professionals to avoid constraints during trainings of healthcare providers.
- Promote gender integration training for civil society groups to promote gender equality. Topics to be discussed include: gender equality, gender-based violence, sexual and reproductive health rights. The goal is to build a society where women and men share equal responsibilities in all aspects related to sexual and reproductive health and choosing the number of children.
- **Select 35% of health units in Luanda and Huambo** to receive in depth FP assistance. The selected health units will benefit from communication activities, on job trainings, (re)activation of youth friendly services and integration of services such as FP and HIV, FP and Malaria, FP and immunization, post-partum FP, etc.
- **Support MOH department of communication** in 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.
- **Engage new stakeholder such as** Ministry of Youth and Ministry of Education to promote sexual and reproductive education and family planning among youth in and outside school to reach more adolescents.

4.6 Proposed Targets for Q4 FY18:

In 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 with providers in municipal levels.
- Disseminate, at provincial and municipal levels, the FP norms and protocols such as:
 - 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 Direction 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
	Q4
1. Percentage of USG-assisted service delivery points (SDPs) offering FP/RH counseling or services.	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
3. Couple years protection in USG supported programs.	14,764
4. Percentage of health facilities whose providers reported a Quality of Care score \geq 80% for management of FP services (+).	40%
5. Number of health care workers who successfully completed an in/service training program.	40
6. Number of protocols finalized and approved.	1
7. Number of people trained with USG funds.	70
8. Number of USG-assisted community health workers (CHWs) providing Family Planning (FP) information, referrals, and/or services during the year.	N/A

4.7 Environmental Mitigation Monitoring Plan (FY18):

Activities under IR4 have a status of categorical exclusion and do not require reporting.

4.8 Improved RMA Capacity in Management and Implementation of Health Programs:

To improve RMA's capacity in implementation high quality health programs, three new employees were recruited, namely: human resources manager, program manager and finance coordinator. These new staff will help RMA to have better HR and finance procedures.

- **Human resources** – The new HR staff is being trained by PSI HR manager. This training will allow an experience exchange and align RMA's human resources procedures to the most updated requirements. Besides, the new human resources manual is being finalized.
- **Finance** – RMA finance department have been receiving constant support from PSI's finance department to improve the financial procedures. Until now, RMA uses Excel for the accounting. It was recommended to switch to Primavera ERP (the most used accounting software in Angola) to improve its financial procedures. The Primavera supplier was identified who also will provide training for RMA staff.
- **Monitoring and Evaluation** –Monitoring and evaluation of the data quality was conducted. It was found that there were some discrepancies between the data presented in the report and the data in the files. To improve data quality and accuracy, PSI's M&E team has proposed a new database to collect and analyze the data to avoid errors in counting the number of people reached as well as

the number of SBCC activities conducted. The database has been installed and RMA staff has received the training and started using the new database and tools.

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

5.1 Background

5.1.1 Finance and Governance Strengthening

During the previous quarter, due to the lack of responses and approval from the MINSA authorities for the implementation of strategies at provincial and municipal levels, the alternative of implementing a contingency plan was discussed with USAID. Thus, under the Governance and Finance component, USAID defined the main topics/areas to be prioritized as follows:

- Implementing an iCCM costing study in community health on interventions regarding malaria, diarrhea, and pneumonia
- Implementing a needs assessment in the National Malaria Control Program (NMCP) to carry out a capacity building plan in order to develop management capacities and performance improvement

5.1.2 Health Information System Strengthening

Under the Health Information System Strengthening component, USAID has 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

Under the Governance and Finance component, for FY18, HFA had defined the strengthening of provincial and municipal capacities in annual planning, budgeting, and monitoring interventions in Zaire and Lunda Sul Provinces. However, the MOH has not approved implementation of these strategies. As a consequence, USAID and PMI agreed that HFA should focus on the following priorities: 1) implementing the iCCM Costing Study intervention (malaria, diarrhea, pneumonia) on community health for the provinces of Zaire and Lunda Sul, and 2) carrying out the needs assessment of the National Malaria Control Program (NMCP) to begin a process of capacity building to improve their management capacities and performance.

5.2.2 Health Information System Strengthening

PMP indicators on Health Systems Strengthening are presented in the table below. Over time, yearly or quarterly targets need to be adjusted due to recommendations from GTI/GEPE to increase the number of persons to be trained or to change the order of provinces due to strategic purposes (e.g. start with provinces already trained by GEPE on Monitoring and Evaluation or provided with computers from another donor/partner). These changes are sometimes difficult to foresee in advance, given the decision-making processes of the MOH. Here, we present the targets as they were set up by the beginning of the quarter, before the changes occurred. In section 5.6 (proposed targets for Q4), we suggest new targets based on

these changes. As observed in the table 1 below, the number of people trained in DHIS2 in Q3 were almost double the quarterly targets, due to a substantial increase in the number of trainees per municipality, as recommended by GEPE-GTI.

Table 1- DHIS2 performance indicators during Q3

Performance Indicators	Baseline 2015-16	Target 2018	Quarter targets for FY2				Achieved in Quarter 3 / Quarter 3 Target	Achieved in Quarter 3 / Year Target
			Q1	Q2	Q3	Q4		
Number of DHIS2 users trained within MOH with USG assistance *	N/A	142	N/A**	8	50	84	93 [^] / 50 (186.0%)	101 [^] / 142 (71.2%)
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	N/A**	N/A**	N/A**	43	N/A	N/A

[^] 93 users reported as trained in DHIS2 in Q3 include 70 users trained in Uige in May-June, and 23 users trained in Malange in June-July 4th. An additional 49 users were trained in July 11th-24th, which will be included in the Q4 report.

* After DHIS2 road map and implementation plan (Q1-Q2) it was assumed that 2 people would be trained 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), making a total of 142. This assumption will be revised in proposed targets for Q4.

** Not targets for some indicators in Q1, Q2 and/or Q3 due to the roll out phases of DHIS2.

***It corresponds to 70% of 61 municipalities (total number of municipalities in 6 PMI provinces).

5.3 Major Achievements during Q3 FY18:

5.3.1 Finance and Governance Strengthening

a) Strengthen capacities for iCCM costing analysis

Over Q2, HFA Project shared with Director of the National Department of Public Health (DNSP), Dr. Isilda Neves, the scope of work and outcomes expected, and presented the iCCM costing study strategy to Daniel Minji from Social Support Fund (FAS), who highlighted that the analysis is timely, relevant, and strategic for the health community interventions. In Q3, the methodological approach was presented to the malaria's stakeholders in the Malaria Operational Plan Workshop, where the participants agreed with the expected results. Finally, HFA got the final approval from USAID to start the implementation of the iCCM costing analysis on community health. HFA Project will provide technical assistance to carry out an iCCM costing study. The analysis will support the MOH and Ministry of Administration and Territory (MAT) to develop its community-based interventions to reduce the impact of malaria and other key childhood diseases such as diarrhea and pneumonia while strengthening the community health system that supports such interventions. The analysis will help the MOH to plan the interventions and to advocate for and mobilize enough financial resources for its sustained implementation. The analysis will be developed over July and August 2018.

The methodological approach includes the following steps: identification of bottlenecks within the community health system; modeling the cost of implementing the national community health program based on defined packages of services; prepare financing options for the National Community Health Program; determine the impact of community health investment on preventable deaths; and training a national team on using the costing tools. At the end of the analysis, USAID – HFA Project will share and validate the results of the study with MOH, MAT, and key stakeholders.

b) Strengthen management capacity of the NMCP

USAID - HFA received final approval from the Secretary of State of MOH for the implementation of a needs assessment on the management capacities of the National Malaria Control Program (NMCP). The needs assessment objective is to identify management areas of the NMCP that needs improvement to strengthen its institutional performance through a capacity building process. Then, HFA will carry out a process including: identify management strengths and weaknesses; identify areas of improvement; develop recommendations to address the areas that requires intervention; and establishing a framework for a capacity building plan that includes interventions, their sequence, the resources required, and the timeframe for implementation. The process was designed to take approximately three months and the methodological approach includes interviews with key stakeholders and a consensus workshop. Once finished with the needs assessment, USAID - HFA Project will share the final report with the NMCP partners and malaria stakeholders.

5.3.2 Health Information System Strengthening

DHIS2 and Health Digital Systems

Major achievements in Q3 FY2018 included the kick off of the DHIS2 training in the PMI provinces (Annex 2 – Success Story). Two criteria influenced the order in which the provinces were chosen to be trained. The first criterion was to start with provinces for which the World Bank would provide computers (covering every municipality and provincial health department), while the MOH purchased computers for the remaining provinces with funds from the Global Fund. The second criterion was to start with provinces where GEPE had already trained health personnel on monitoring forms using funds from Global Fund, so trainees could be better prepared to understand DHIS2. With this criteria Uíge was selected as the first province to be trained, followed by Malanje.

DHIS2 Training						
Province	Implementation Period	# Municipalities covered	# Computers for distribution	# technicians trained at municipal level	# technicians trained at province level	Total # of Technicians trained
Uíge	May-June	16	17	64	6	70
Malanje	June-July (4th)	5	6	19	4	23
Total		21	23	83	10	93

Number of people trained and content of training. During Q3, HFA trained a total of 93 health technicians, covering the entire province of Uíge, and 5 municipalities from Malanje. Based on suggestions from the GTI-GEPE, trainees included approximately four technicians from each municipality and four at the provincial level (one statistician and three focal points: one for malaria, one for epidemiological surveillance, and one or HIV/reproductive health). The agenda acknowledged a wide range of trainees and started with getting them familiar with computers and the use of a mouse, quickly covering data collection problems, and moving into the heart of the training: DHIS2 data insertion, data analysis, and data use (Annex 3 – DHIS2 Training Agenda).

A competency-based approach has been used for all training. In the months prior to training, work was done with GEPE/GTI and external experts to identify and document the core competencies (skills and knowledge) that municipal staff would require to work with DHIS2, and the training was designed around

this set of competencies. All trainers have been sensitized to this competency-based approach, and training has been very goal-oriented (e.g. continually testing whether participants have achieved competencies and flexing the agenda where necessary to ensure they do) rather than process-oriented (e.g. simply delivering a pre-determined training agenda). During the training, a user manual and a basic IT concepts manual (produced by HFA) have been provided to each municipality team and provincial health department, so they have written support materials at their office. In addition, they have received a single page summary on how to turn on a computer and how to access DHIS2 for display on the walls of their office, for easy reference.

Trainers. The training has been a collaborative effort between HFA, GTI, and GEPE. Each province has been divided into groups of no more than 25 trainees with a team of trainers composed by one person from each program. Additionally, one person from NMCP has participated in the refresher on the malaria paper forms and different problems trainees need to solve before inserting data into DHIS2.

Distribution of computers at municipal and province level. Per the request of GTI, HFA has been in charge of distributing and installing computers donated by World Bank and USAID in each of the municipalities and provincial health departments, even those in more remote and difficult to access areas. A total of 23 computers were distributed in Q3 in Uige and Malanje with the purpose of making DHIS2 implementation feasible.

Supervision at municipal level and reporting rates. In the weeks following the training, IT personnel from HFA traveled to the municipalities to identify any potential problem with DHIS2 and find the respective solutions. The result of this measure and the interest in using DHIS2 by municipal personnel can be seen in the following table. After the training, the reporting rate for the January-June period reached 56.4% overall in Uige, and it is expected to increase in the following weeks. In at least five municipalities, the reporting rate reached over 80.0% or 90% (Sanza, Puri, Mucaba, Quimbelea, and Cangola: data not shown here).

It is expected that reporting rates presented below will also increase, after GTI-GEPE complete the Health Mapping Exercise and clean the current list of health units listed on DHIS2. For example, during the supervision conducted by HFA personnel in Uige after the training, it has been found that out of 106 health units listed on DHIS2, 12.8% do no longer exist, are not operating (waiting for inauguration or still under construction), or do not routinely send reports to the municipality (because they are far from the municipality or they don't have budget to hire full time technical staff). In Malanje, 11.4% out of 123 health units, present similar problems.

Reporting Rate of Malaria Form in DHIS2			
January to June 2018			
Province	Inserted**	Expected	%
Uige	1,211	2,148	56.4
Malanje	433	1,044	41.5
Kwanza Norte*	517	870	59.4
Bié	71	1,020	7.0
Cunene	13	840	1.5
Moxico	9	732	1.2
Luanda	9	1,410	0.6
L. Norte	2	552	0.4
L. Sul	0	768	0.0
Bengo	0	312	0.0
C. Sul	0	1,818	0.0
Huíla	0	1,368	0.0
Cabinda	0	714	0.0
Namibe	0	474	0.0
Cuando Cubango	0	516	0.0
Benguela	0	1,506	0.0
Huambo	0	1,674	0.0
Zaire	0	534	0.0
TOTAL	2,265	18,300	12.4

* The values for Kwanza Norte are due to a recent DHIS2 training conducted by HFA (finished on the week of August, 2018), showing the immediate impact of the training on reporting rates.

** Note that some provinces not yet trained by HFA are already reporting data in DHIS2 (Bie, Cunene, Moxico, Luanda and Lunda Norte). These are provinces where GEPE has conducted the referred training on monitoring and evaluation with support from Global Fund weeks before HFA. In such training, GEPE dedicated one-three days as an introduction to DHIS2.

Creation of Provincial Technical Groups. During the DHIS2 training in Uige and Malange, HFA, with GTI-GEPE, created provincial technical groups, with representatives from the municipal and provincial health departments, so they can give continuity and support the DHIS2 implementation. One of the immediate actions of these groups has been to accompany HFA IT personnel into each of the municipalities after the DHIS2 training, to confirm that no problems are encountered by municipal personnel in inserting data and accessing DHIS2. They are expected also to be involved in organizing and participating in the forthcoming data use meetings.

Health Facility Mapping: Collaborative Work with PASSII. In Q3 HFA supported GEPE and PASSII towards cleaning the list of health units for DHIS2. With support of our Global IT Expert, 2,934 health unites were extracted from DHIS2 and compared against 2,774 health units from the official Health Facility Map (Mapa Sanitário) held by GEPE. Out of the jointly effort in matching both lists, the following results were obtained:

Findings of Matching Exercise		Suggested Action to be taken
Facilities that were successfully matched on both lists	2,349	These will be updated in DHIS2 to show the correct name and code.
Facilities in Mapa Sanitária but not yet in DHIS2	425	These will be added to DHIS2.
Duplicates identified on DHIS2	24	These will be removed from DHIS2.
Facilities in DHIS2 but not in Mapa Sanitária	560	HFA is doing analysis to determine which users have created these facilities, and GEPE/PASSII will then validate these facilities with them, and determine which facilities should be removed, and for which facilities codes should be generated.

The goal of this exercise is that once validation is completed, GEPE will stop using an Excel-based master facility list, and DHIS2 will become the core national master facility list.

Monitoring Activities with the NMCP-MOH

In collaboration with staff from the NMCP, the HFA M&E Adviser supported in Q3 the MOH on a wide range of activities, listed below:

1. Technical assistance to GEPE/MINSA to finalize and submit the Global Fund concept note on Health System Strengthening (submission in April 2018).
2. Finalize the National Monitoring and Evaluation Plan 2018-2020 for the NMCP that will be presented to the MOH and partner organization for validation.
3. Support the revision of the Malaria Commodities Forecast Report 2017-2019, in order to include recent needs from 29,000 refugees from Congo into the province of Lunda Norte.
4. Participated in the training of DHIS2 with NMCP staff explaining the malaria form and harmonization processes in Uige.
5. Support Vector Works in the elaboration of the NMCP norms to distribute mosquito nets for routine distribution.
6. Support NMCP to respond questions from Global Fund prior to signing the new implementation contract of the approved Malaria Concept Note 2018-2021.
7. Collaborate in the quantification of fever episodes, malaria cases, and RDT needs in four municipalities for the iCCM project.
8. Improve the NMCP capacity building indicator table (**Annex 4 - Success indicators for NMCP in Malaria.**)

Research Activities

OR: South East Asian Migrant Study. In May 2018, HFA submitted to PMI – DC the revised version of the protocol and instruments. In June, HFA shared the proposed budget for the study, per request of the review committee. Comments from this committee were received by HFA on July 23rd. It is expected that the final version will be approved by PMI-review committee in Q4 and submitted to the CDC IRB. Fieldwork is set to take place in FY2019.

5.4 Major Constraints faced during Q3 FY18:

5.4.1 Finance and Governance Strengthening

Like other components of the USAID - HFA Project, the major constraint has been the delays in approvals by the MOH to start the implementation of strategies and activities included in the HFA Project work plan. The strategy to overcome these constraints has been the implementation of the contingency plan, i.e., avoiding spend time and effort waiting for the MOH decision for provincial and municipal interventions (plans and budgets), and focus on the two strategies described above in 5.3.1.a and 5.3.1.b.

Health Information System Strengthening

Some challenges in Q3 were similar than those reported in Q2: not very strong coordination from the MOH on the efforts from different partners on DHIS2 implementation. This lack of coordination resulted in MOH health departments not always knowing about decisions taken by GTI/GEPE or other partners. Additionally, middle level authorities at MOH seemed to be afraid of taking clear and immediate decisions/actions towards DHIS2, due to fears from higher level authorities (e.g. fears of participating in internal meetings on DHIS2 on preparative work, hesitation to call for the Extended Technical Working Group meetings, delays in approving the kick off of DHIS2 training, etc.).

Lack of equipment for DHIS2 roll out continues to be a problem: out of 43 computers promised by MoH to fully cover Uige, Malange and Kwanza Norte, only 20 computers were made available (donations from World Bank). Before this scenario, HFA purchased prior approval from PMI-USAID Angola the remaining 23 computers to cover Malange and Kwanza Norte. It is expected that MoH with Global Fund money would purchase computers for 161 municipalities and will cover the 3 remaining PMI provinces (Zaire, Lunda Sul and Lunda Norte). Nevertheless, the timing for procuring these computers is unclear, putting at risk the DHIS2 training chronogram. HFA might need to buy computers for these other 3 provinces, in order to accomplish DHIS2 training of all 6 PMI provinces by the end of September.

5.5 Recommendations for Remaining of FY18:

5.5.1 Finance and Governance Strengthening

Strengthen communication mechanisms and coordination for implementing HFA Project strategies and activities with key partners involved in governance and financing topics, including MOH (NHPD, NMCP, GEPE), MAT and FAS. Now, when two institutional strengthening strategies begin to be implemented by HFA Project, it is important to set dates on the agenda to share with the institutional counterparts the progress and constraints and obtain the expected outcomes without major setbacks.

5.5.2 Health Information System Strengthening

During the remainder of Q4, HFA recommends continuing to work together with other partners (EU, WHO, PSM, etc.) to support GTI/GEPE and reinvigorate the Extended Technical Working Group meetings, as well as to continue having bilateral meetings with partners to have a closer look at what they are doing and how to jointly improve DHIS2 implementation.

Increase involvement of NMCP, through one of its staff members and through the HFA M&E advisor to improve the culture of data analyses at all levels of the MOH. This means to initiate meetings with municipal and provincial level officials (where DHIS2 training already occurred), in order to analyze data for decision making. At the central level, support GTI-GEPE to have DHIS2 data available for presentation at each of the regular meetings with the MOH, so high level officials also increase their positive perception of DHIS2 and endorse their support of DHIS2 as the national health information platform.

5.6 Proposed targets for Q4 FY18:

5.6.1 Finance and Governance Strengthening

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

Since HFA Project main goal is to provide technical assistance to strengthen capacities for developing a costing iCCM analysis, during quarter 4, this goal will be concluded, after having collected the health community services information, among the different organizations involved (MOH, MAT, FAS, etc.), being able to present a final report. In additions, it will be necessary to follow up on the results of the study of health services (e.g. malaria, diarrhea and pneumonia) costs at the community level, and how the counterparts intend to share and use the information obtained with key decision makers. In addition, it will be important to create a technical group with the responsibility to share the final costing study results with stakeholders.

- **Strengthen management capacity of the NMCP started**

As mentioned in the previous paragraph, the Q4 methodological approach will be approved by MOH and USAID and the fieldwork will be ongoing (interviews to stakeholders and consensus workshop). Once the needs assessment management capacities of the NMCP are carried out, it will be necessary to follow up on the results of the assessment, as well as the methods of capacity building plan implementation by NMCP. Possibly additional support from other stakeholders is going to be needed. As a result of the assessment, some capacity building activities will be included in the NMCP annual work plan, and in the next fiscal year of the HFA Project (FY19).

5.6.2 Health Information System Strengthening

Section 5.2.2 targets were presented in the beginning of Q3. In the following table, increased targets are being proposed and submitted to PMI-USAID for consideration, in line with GEPE/GTI suggestions to increase the number of people to be trained in each municipality.

Performance Indicators	Target FY2018	Target Q4
Number of DHIS2 users trained within MOH with USG assistance *	278	177
Percent of municipal HMIS reports submitted on time and complete	70%	70%
Number of municipal authorities meeting quarterly to review HMIS data and incorporate feedback in reports	43**	43**

*Revised: It assumes training 4 people at municipal level (4 x 61=244), 4 at provincial level (4 x 6=24), 2 at central level (GEPE/GTI), 2 at NMCP, and 6 trainers of trainers (TOT).

**It corresponds to 70% of 61 municipalities (total number of municipalities in 6 PMI provinces).

Specific dates for DHIS2 training in remaining provinces and supervision are presented on Annex 5 - DHIS2 Training and Supervision Chronogram for Q4 FY2018.

- **Interoperability Activity Following Health Tech Camp**

Pending approval from the US State Department, HFA is organizing a follow-on activity for the Health Tech Camp conducted in Q2. The activity, called a ‘Connectaton’, is expected to take place in Q4, previous approval from the US State Department and agreement of final dates with all partners involved (GTI, Consultant and US State Department). During the ‘Connectaton’, programmers from GTI, PSI, and PSM will complete the design and prototyping of interoperability between DHIS2 and OpenLMIS, enabling the

automated sharing of health facility lists. The workshop will be led by Dr. Carl Leitner, an interoperability specialist with Digital Square. The outcomes of the workshop will be:

1. OpenHie/OpenHim interoperability standards and tools for a health facility registry are set up.
2. Both DHIS2 and OpenLMIS are connected, and health facility lists are successfully shared.
3. MoH and partner staff are trained in key interoperability concepts and techniques and gain practical experience in implementing interoperability.

➤ ***OR: Southeast Asian Migrant Study***

After final approval of the study design and tool from the PMI review committee, the study will be submitted by PMI-DC to the CDC IRB. Fieldwork is expected to take place during FY2019.

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.

List of Annexes

Annex 1 - Supervision Results: Assessment of health workers knowledge and good practices on malaria case management

Annex 2 – Success Story (Health System Strengthening)

Annex 3 – DHIS2 Training Agenda

Annex 4 – Success indicators for NMCP in Malaria

Annex 5 - DHIS2 Training and Supervision Chronogram for Q4 FY2018

**Annex 1 – Supervision Results: Assessment of health workers
knowledge and good practices on malaria case management**

PRENATAL CARE AND EMERGENCY ROOM WITH PREGNANT WOMEN *

Descriptive Statistics	N	% that answered I=Yes
CPN_1.1_ Confirms the gestational age of the pregnant woman.	47	100,0
CPN_1.2_ Confirms that the woman is not allergic to Sulfadoxine Pyrimethamine / SP or other sulphonamides	40	82,5
CPN_1.3_ It administers the first dose of SP if the gestational age is equal to or greater than 13 weeks or, if the pregnant woman already feels the fetal movements regularly.	41	78,0
CPN_1.4_ After the 1st dose of SP, do you give the other doses of SP with a minimum interval of 30 days between doses up to the day of delivery?	41	92,7
CPN_1.5_ If the pregnant woman is taking TIP with SP, the nurse should reduce the dose of folic acid to less than 5 mg / day	39	76,9
CPN_1.6_ If the mother is HIV positive and while taking cotrimoxazole, she should not take SP	37	64,9
CPN_2.1_ Question for signs and / or symptoms that the pregnant woman presents or feels?	45	97,8
CPN_2.2_ Take the main vital signs (t° measurement, blood pressure, pulse and respiratory rate) and makes a general physical examination?	47	100,0
CPN_3.1_ If the pregnant woman during the first trimester of pregnancy has the result of TDR or M.O-positive, the nurse prescribes oral quinine treatment.	48	91,7
CPN_3.2_ If the pregnant woman during the first trimester of pregnancy has the result of TDR or MO-positive, the nurse prescribes oral quinine treatment. If the pregnant woman is in the 2nd or 3rd trimester of pregnancy with TDR or MO positive, the nurse prescribes Artemether / Lumefantrine (Coartem) or artesunate / amodiaquine (ASAQ), or Dihydro Artemisinin + Piperaquine (Duo-Coctexin) correctly according to the National Treatment Protocol?	48	81,3
CPN_3.3_ Do you administer antipyretics or make cold dressings to control the fever?	48	91,7
CPN_4.1_ If the nurse recognizes the major signs and symptoms of severe malaria (high fever, frequent vomiting, seizures, loss of consciousness, etc.)	48	93,8
CPN_4.2_ If the nurse provides the first aid to the pregnant woman (immobilizes SOS, inserts artesunate into a rectal suppository, injects diazepam) and immediately transfers it to the referral hospital?	48	72,9
CPN_5.1_ If the nurse delivers an MTILD or provides information on where the expectant mother can get it, and advises how to use it every night?	48	85,4
CPN_5.2_ If the nurse talks about the importance of the need for the pregnant woman to correctly take all the medicines that are prescribed to her.	48	87,5

* Green color represents where items have the highest score, and gray color when items have the lowest score.

PEDIATRICS WITH EMERGENCY ROOM *

Descriptive Statistics	N	% that answered I=Yes
PED_1.1_ Ask the mother / father if the child had constant vomiting, very high and frequent fevers, seizures.	49	85,7
PED_1.2_ Ask the mother / father if the child had constant vomiting, very high and frequent fevers, seizures.	49	69,4
PED_1.3_ Checks if the child is lethargic with stare or unconscious.	49	79,6
PED_1.4_ Check for signs of respiratory distress.	49	65,3
PED_1.5_ Search for fever (37.5 ° or more) or low body temperature (35.5 ° or less).	49	83,7
PED_1.6_ The technician performs the TDR or requests a PP, and interprets the results correctly.	49	91,8
PED_1.7_ If you find any symptoms or signs of danger, stabilize the child and transfer it urgently to the nearest referral hospital.	49	89,8
PED_2.1_ Research the presence of nuchal rigidity, bulging fontanelle, and other signs of danger.	49	71,4
PED_2.2_ Research signs and symptoms of malaria (fever, diarrhea, vomiting, irritability, seizures).	49	95,9
PED_2.3_ If you suspect malaria, the technician does the TDR.	49	87,8
PED_2.4_ If the TDR is positive and / or observes any general signs of danger or stiffness of the neck, the technician channels a vein, gives the first dose of artesunate, artemeter or quinine, and administers fever-reducing medicine and transfers it to the child.	51	80,4
PED_2.5_ If the TDR is negative and there are no signs of danger, administer analgesic / antipyretic and recommend home care and come back after a day to re-evaluate the child.	51	84,3
PED_3.1_ If the TDR is negative and the signs and symptoms of malaria persist, - ask the PP and make a new evaluation looking for other diseases of febrile syndrome.	51	86,3
PED_3.2_ If the result of TDR or PP is positive, and the child has no general signs of danger or stiff neck, prescribe Coartem, ASAQ or Duo-Cotec-xin in accordance with the national treatment protocol.	51	96,1
PED_3.3_ Do you administer antipyretics or make cold dressings to control fever?	48	89,6
PED_3.4_ Gives an MTILD or gives information on where it can get it, and advises parents how to use it every night	48	75,0
PED_3.5_ It advises parents to take all medications as prescribed.	48	95,8

* Green color represents where items have the highest score, and gray color when items have the lowest score.

MEDICINE AND EMERGENCY ROOMS WITH ADULTS *

Descriptive Statistics	N	% that answered I=Yes
MED_1.1_ The nurse asks for signs and / or symptoms that the patient presents or feels?	64	90,6
MED_1.2_ Vital signs (measurement of blood pressure, blood pressure, pulse rate and respiratory rate).	68	92,6
MED_1.3_ Ask about symptoms and signs of malaria (fever, headache, joint pain) or other febrile illnesses.	68	97,1
MED_1.4_ Discard other diseases that may have the same symptoms and signs of malaria?	68	75,0
MED_1.5_ In case of suspected malaria, do the TDR and / or request a Plasmodium Search (PP), and correctly interpret the results?	68	83,8
MED_1.6_ If the result of the TDR is negative and still suspected of malaria, the technician requests a PP and makes a new evaluation looking for other diseases (differential diagnosis)	68	76,5
MED_2.1_ If the result of TDR or M.O is positive, does the technician prescribe the artemether / lumefantrine (Coartem) or artesunate / amodiaquine (ASAQ), or Dihydro Artemisinin + Piperaquine (Duo-Coctexin) treatment correctly according to the National Treatment Protocol?	68	89,7
MED_2.2_ Do you administer antipyretics or make cold dressings to control the fever?	68	88,2
MED_3.1_ Promptly attends critically ill patients suspected of complicated malaria.	68	95,6
MED_3.2_ The technician administers the artesunate or Artemeter attack dose according to the national treatment protocol, stabilizes the patient and immediately transfers it to the referral hospital.	68	85,3
MED_4.1_ Does the technician provide information on malaria prevention measures?	61	73,8
MED_4.2_ If the technician talks about the importance and necessity of the patient to take correctly all the medicines that are prescribed to him.	61	91,8

* Green color represents where items have the highest score, and gray color when items have the lowest score.

Annex 2 – Success Story (Health System Strengthening)

Success Story

Living and Learning

It is in the most distant and hard-to-reach areas that technological innovations tend to come last.



Group of health data technicians during DHIS2 training in Uíge Province

With the presence of the HFA project in the municipality of Buengas, Uíge province, several health data technicians had the opportunity to have their first contact with laptops and develop their skills in using DHIS2, improving the way reports used to be sent.

Buengas is one of the 16 municipalities in the Uíge Province. This municipality is another example of the difficult access that many people face due to the bad road conditions and the long distances from the provincial headquarters as it is located approximately 250 kilometers, or 10 hours by car, from Uíge's capital.

In Buengas lives the hero of this story, Mr. Albino João Mutia, responsible for the statistics at the Municipal Health Direction.

Mr. Albino Joao, like many other data technicians in Angola, barely had contact with computers during his professional life. During a recent DHIS2 training of about 70 municipal and provincial health data technicians in Uíge (held May 28th to June 30th), Mr. Albino Joao was initially afraid to use a computer and he trembled when trying to use the mouse for the first time in his life. The trainer soon realized that the 10 other data technicians were experiencing the same situation. What was impressive was Mr. Albino João's commitment and dedication is that he understood how such the DHIS2 platform could make his life easier and work more effective. He realized her could save time by providing reports in a quicker way, whenever he needed to send information to the provincial health department. He was so attentive during the instructional sessions that by the end of the training, he was the first person to solve an advanced DHIS2 exercise (creation of pivot tables) and was able to teach the rest of the class how to solve and manage the pivot table application.

Mr. Albino Joao, like the rest of the trainees, is now able to use DHIS2 from his own office to insert health data. From January to June 2018, he and his team have achieved close to a 70% of the malaria reporting rate in this municipality.

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.

Annex 3 – DHIS2 Training Agenda

HFA - PROGRAMA DE IMPLANTAÇÃO E TREINAMENTO DE DHIS2	
Dia	Obejctivo
Dia 1	segunda-feira, 28 de Maio de 2018
	Apresentação do Projecto HFA à DPS
	Abertura do treinamento
	Formação básica de informática
	Fim da sessão
Dia 2	terça-feira, 29 de Maio de 2018
	Formação básica de Informática - MS Office
	Fim da sessão
Dia 3	quarta-feira, 30 de Maio de 2018
	Uso e Importancia da Informação
	Introdução ao DHIS2
	Fim da sessão
Dia 4	quinta-feira, 31 de Maio de 2018
	O SIS de Angola
	Harmonização de dados antes da inserção no DHIS2
	Inserção de dados no DHIS2
Dia 5	sexta-feira, 1 de Junho de 2018
	Inserção de dados no DHIS2
	Submissão e aprovação de dados
	Módulo de análise de dados - Indicadores de programas
	Fim da sessão
Dia 6	sábado, 2 de Junho de 2018
	Módulo de análise de dados - Tabelas dinamicas
	Fim da sessão
Dia 7	segunda-feira, 4 de Junho de 2018
	Actividade em paralelo com o Director da DPS e os Directores das DMS da Província: Tema: O SIS de Angola e o DHIS2, supervisão e aprovação de dados no DHIS2 Nota: Data susceptível a alteração.
	Módulo de análise de dados - Tabelas dinamicas
	Fim da sessão
Dia 8	terça-feira, 5 de Junho de 2018
	Módulo de análise de dados - Visualizador de dados
	Módulo de análise de dados - O SIG
Dia 9	quarta-feira, 6 de Junho de 2018
	Módulo de análise de dados - Dasboards
	Fim da sessão
Dia 10	quinta-feira, 7 de Junho de 2018
	Módulo de análise de dados - Dasboards, interpretações e mensagens
	Modulo de relatório - Relatorios de ficha
	Modulo de relatório - relatorios padrão
	Modulo de relatório - resumo de taxa de reportagem
Dia 11	sexta-feira, 8 de Junho de 2018
	O SIS - O impacto dos dados na tomada de decisões
	O sistema de atendimento e suporte sanitário - SASS
	Recapitulação e revisão
	Exame de avaliação
	Fim da sessão
Encerramento da actividade	

Annex 4 – Success indicators for NMCP in Malaria

USAID Health for All RFA-654-16-000004					
Capacity Building Indicators - M&E / NMCP					
Activity (*)	Indicator	FY2018 Targets	FY2018 (til June) Results	Report Schedule	Responsible Party
Objective: Strengthening Malaria Data Collecton, Analyses and Reporting Skills among NMCP and MOH Staff					
Capacity Building Activities / Workshops at National and Subnational Level on M&E, Report Writing, Etc.	# of Trainings/Workshops on M&E and Surveillance Tools Conducted to NMCP/MOH staff	1	1 (Luanda: M&E training: Oct. 2017)	Annual	PSI
	# of Fieldwork Visits Carried Out with NCMP Staff to Reinforce M&E Skills on Malaria Activities	At least 1	1 (DHIS2 training: May 2018)	Based on programmatic needs	PSI
	# of Malaria Reports Written for MOH/Donor in Conjunction of NMCP Staff Based on Malaria Data	2	3 (Malaria Annual Report: Dec 2017; Forecast of Malaria Comodities : May 2018; Monthly Bilateral Meetings DNSP/MOH/USAID: Oct 2017-Jan 2018);	Monthly / Quarterly	PSI
	# of Malaria Strategic Documents Produced / Revised in Collaboration with NMCP staff	2	2 (National Malaria M&E Plan 2018-2020: Jul 2018; HSS Concept Note: Apr 2018).	Base on programmatic needs	PSI
Objective: Strengthening NMCP Skills on DHIS2 for Data Analysis and Decision Making					
On job training / sessions on DHIS2 analyses and data use for decision making	# of NMCP officials with demonstrated skills to produce tables / graphics on malaria key indicators	2 **	/	Annual	PSI
	# of NMCP officials participating in quarterly meetings to review DHIS2 dashboard to incorporate feedback in reports	2 **	/	Quarterly	PSI
	# of DHIS2 malaria reports electronically approved / revised by NMCP along the year	TDB **	/	Monthly / Quarterly	PSI
Objective: Improvement of M&E tools and databases within the overall HMIS (in coordination with NMCP staff)					
Harmonization and integration of M&E tools in the overall HMIS, in coordination with NMCP staff	# of tools / reports on harmonization on malaria produced in collaboration of NMCP and MOH staff	1	3 (Malaria-ICCM report template & guidelines, March 2018; Harmonization Data Meeting with Health Programs of MOH: Dec 2017; Malaria dabased restructured include municipal level data: Jan 2018).	Annual	PSI
	# of tools / actions conducted for data quality improvement	1	1 (Data quality control Rules Created in the electronic malaria monthly report template for DHIS2: April 2018)	Annual	PSI
* Activities listed here are conducted in conjunction with the NMCP staff, and are meant to increase their M&E capacity, thru an on job coaching approach					
** Target to be discussed with NMCP. Planned to be achieved after DHIS2 training					

**Annex 5 - DHIS2 Training and Supervision Chronogram for Q4
FY2018**

SAÚDEPARATODOS

Q4 FY2018

DHIS2 TRAINING CHRONOGRAM *

Province	# of Municipalities	Departure Date	Returning Date	Num. of Days in Province	Groups	Num. Of Trainees
Malanje	9	7/11/2018	7/24/2018	14	2	49
Kwanza Norte	10	7/29/2018	8/11/2018	14	2	43
Zaire	6	8/19/2018	9/1/2018	14	1	27
Lunda Sul	4	8/19/2018	9/1/2018	14	1	19
Lunda Norte	10	9/2/2018	9/15/2018	14	2	43

* The entire province of Uige and 5 municipalities of Malaje were trained in Q3 FY2018

SUPERVISION CHRONOGRAM *

Province	# of Municipalities	Departure Date	Returning Date	Num. of Days
Uige	16	7/8/2018	7/18/2018	11
Malanje	14	7/25/2018	8/3/2018	10
Kwanza Norte	10	8/11/2018	8/18/2018	8
Zaire	6	9/1/2018	9/6/2018	6
Lunda Sul	4	9/1/2018	9/4/2018	4
Lunda Norte	10	9/15/2018	9/22/2018	8

* Right after the DHIS2 training, HFA personnel (IT's) in coordination with province level personnel should visit municipalities to assure that trainees encounter no problems with data insertion. The table present estimated dates.