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HEALTHFORALL

Population Services International (PSI)

Cooperative Agreement No.: AID-654-A-17-00003

YEAR 3 QUARTER 1 PROGRESS REPORT

October 1st to December 31st, 2018

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ACRONYM LIST

ACT	Artemisinin-based Combination Therapy
ADECOS	*Agentes de Desenvolvimento Comunitário e Sanitário* (community development worker)
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
DFID	Department for International Development
DHIS2	District Health Information System 2
DHS	Demographic and Health Survey
DHP	Dihydroartemisinin-piperaquine
DNSP	Direcção Nacional de Saúde Pública (National Department of Public Health)
DPS	Direcção Provincial da Saúde (Provincial Directorate of Health)
EMMP	Environmental Mitigation and Monitoring Plan
EPI	Expanded Programme on Immunization
FP	Family Planning
FP/RH	Family Planning and Reproductive Health
GF/GFATM	Global Fund-The Global Fund to Fight AIDS, Tuberculosis and Malaria
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
ICTT	Index Case Testing and Tracing
IEC	Information, Education and Communication
INLS	Instituto Nacional de Luta Contra a SIDA
IPC	Interpersonal Communication
IPTp	Intermittent Preventive Treatment in Pregnant Women
IR	Intermediate Results
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

MCM	Malaria Case Management
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 Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Prenatal care
PPP	Public-Private Partnership
PSI	Population Services International
PSI/A	PSI/Angola
GHSC/PSM	Global Health Supply Chain Program-Procurement and Supply Management
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
SMM	Municipal Malaria Supervisors
SMPS	Municipal Supervisor for Health Promotion
SOP	Standard Operating Procedure
SOW	Scope of Work
SP	Sulfadoxine-pyrimethamine
SPM	Provincial Malaria Supervisors
SPPS	Provincial Supervisor for Health Promotion
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendants
TH	Tropical Health, LLP
ToT	Training of Trainers, Trainer of Trainers
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

Background

In January 2017, a Population Services International (PSI)-led Consortium signed the Cooperative Agreement No.: AID-654-A-17-00003 to implement the project Health for All (HFA) from February 2017 to January 2022. HFA includes three health areas: malaria, HIV/AIDS and family planning.

The following report describes the main achievements per objective and expected result that occurred during Quarter 1 (Q1) of Project Year 3, from Oct. 1 to Dec. 31, 2018, or FY19. The report is organized into three primary programmatic-based sections:

1. **Malaria** prevention and treatment activities (Results 1, 2 and 5)

2. **HIV/AIDS** continuum of care (CoC) activities (Result 3)

3. **Sexual reproductive health/family planning** (SRH/FP) activities (Result 4)

The report also includes annexes and a success story for the reporting period.

Executive Summary

The Health for All (HFA) project continued to expand and provide key services in malaria, HIV/AIDS and family planning throughout Angola from Oct. 1 to Dec. 31, 2018, or Q1 of FY19.

Under result 1, which covers the use of and access to long-lasting insecticidal nets (LLINs), a mass distribution campaign of nets was conducted in Moxico, Lunda Sul and Bengo provinces. This campaign saw universal coverage achieved in the provinces, with a total population of 1,969,121 people receiving 1,091,011 LLINs. The National Malaria Control Program, and partners the Global Fund and President's Malaria Initiative, provided the nets.

Previously, malaria services provided through result 2 only covered 24 provinces, but for FY19, they have been expanded to all 60 provinces. This scale up means 100% of health units will be covered by the project, thus more health workers will need training and supervision. To address this increased need, the project trained 409 health workers in the quarter, with 274 health workers trained on artemisinin-based combination therapy, 105 on intermittent preventive treatment in pregnancy and 30 on optic microscopy.

For the work under result 3 in providing high-quality HIV and AIDS services, the project has been implementing index case testing and tracing. The strategy has been shown to yield a higher rate of newly diagnosed HIV cases. Continuing with this promising testing strategy, during the quarter, the project tested and identified patients who were HIV positive at a rate greater than the annual target, assuming a 25% achievement per quarter.

The project also had a productive period in its work with sexual and reproductive health and family planning under result 4. Several delegates and representatives attended the 5th International Conference on Family Planning in Kigali, Rwanda. Additionally, the project collaborated with the Ministry of Social Action, Women and Family and partners to host a radio debate, public session and roundtable meeting that corresponded with the 16 Days of Activism against Gender-based Violence. Finally, the project helped procure a donation of 130,000 injectable contraceptives and will conduct a refresher training on their use.

To strengthen and manage health systems and information under result 5, the project is working on improving data quality, access and use. Integral to this approach has been the implementation of the District Health Information System 2 (DHIS2). Angola's Minister of Health has shown interest in the system, asking HFA staff to support the Ministry of Health in related activities and requesting that provincial governors adopt the platform. The project was also informed that the Minister signed a long-awaited memorandum of understanding with UNITEL, a phone company, that will allow data to be uploaded into DHIS2 at no cost.

Despite challenges the HFA project faces, many improvements have been made and achievements met to ensure the project is providing high-quality, expansive health services to individuals in Angola.

MALARIA

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

1.1 Background

In partnership with the USAID-funded project Health for All (HFA), the National Malaria Control Program (NMCP) aims to achieve universal coverage and increase the access and use of long-lasting insecticidal nets (LLINs) to 80% of the national population. HFA is the main implementing partner for the LLIN distribution campaign, working under the leadership of the NMCP and in coordination with USAID's Procurement and Supply Management (PSM) project (part of the Global Health Supply Chain Program), which oversees the placement of mosquito nets in target provinces and municipalities. To support this campaign, the Secretary of State, who leads the Inter-ministerial Committee to Combat Cholera and Malaria (*Comissão Interministerial para o Combate à Cólera e Malária*), is very committed and interested in having the Population Services International (PSI) communication team actively contribute to the Angolan Government's efforts in malaria communication campaigns. The first contacts happened during this reporting period (Q1 FY19). The LLIN distribution campaign has been implemented and completed in phases (see table 1 below) in 12 provinces, as per agreement with the NMCP and the President's Malaria Initiative (PMI). Distribution in Lunda Norte as an additional province is still underway and should finish in mid Q2.

table **01** Several phases of implementation of an LLIN's universal distribution campaign

	Phase 1	Phase 2	Phase 3	Phase 4
Provinces	Uige Zaire Malanje Kwanza Norte Kwanza Sul	Cunene Namibe	Huambo Cuando Cubango Moxico	Lunda Sul Lunda Norte* Bengo
Quarter	Q2 / Q3 FY17	Q1 FY18	Q2 / Q3 FY18	Q4 FY18 + FY19

* Lunda Norte universal coverage started in Q1 FY19, but due to factors that are mainly related to population estimation (not enough nets), coverage will be completed by early February 2019.

1.2 Summary of achievements in FY18

Since the beginning of the universal LLIN mass distribution campaign, in Q2 FY17, until the end of 2018, HFA managed to cover 12 of the 18 provinces. Results are listed below, and more details included in table 2:

- Total population reached: **10,742,071** people
- Approximate number of LLINs distributed: **6 million** LLINs
- Coverage: **309,178** pregnant women.
- Children reached: **1,776,172** under 5 years of age.

table **02** Results of 12 provinces that concluded an LLIN mass distribution campaign by the end of 2018

Province	# Population	# Pregnant Woman	# Children under 5	# Registered Houesholds	Total LLINs distributed
Malange	1,092,499	28,384	180,733	195,953	597,246
Kwanza Norte	509,109	12,618	79,161	102,925	285,252
Kwanza Sul	1,720,325	41,786	262,066	421,577	990,944
Uige	334,670	9,365	60,955	68,898	186,351
Zaire	602,349	13,519	89,226	130,840	333,684
Cunene	978,240	30,860	139,340	156,873	529,444
Namibe	482,499	15,098	71,148	84,098	266,813
Huambo	2,545,043	82,788	410,727	499,876	1,400,812
Cuando Cubango	508,186	14,444	97,861	110,485	286,543
Moxico	849,469	25,493	159,623	171,065	447,365
Lunda Sul	675,171	21,899	150,857	110,270	365,580
Bengo	444,511	12,924	74,435	91,254	248,086
TOTAL	**10,742,041**	**309,178**	**1,776,172**	**2,144,114**	**5,968,120**

1.3 Targets and Achievements of Q1 FY19

During the reporting period, three provinces started and completed the mass distribution campaign: Moxico, Lunda Sul and Bengo. The coverage of Bengo and Lunda Sul was exclusively supported by USAID/PMI funds and nets. As for Moxico province, to be able to complete universal coverage, an agreement was made between NMCP, the Global Fund (GF) and PMI/USAID for PMI to provide additional nets, since the initial estimated number was insufficient given the increase in population that occurred during the registration period. At the end of distribution in Moxico, the Global Fund contributed **414,168** LLINs, and PMI/USAID contributed **65,482** LLINs.

With universal coverage achieved in Moxico, Lunda Sul and Bengo provinces during Q1 FY19, HFA managed to cover a total population of **1,969,151** people, who received **1,091,031** LLINs in total of the **1,114,578** million nets made available by NMCP partners (GF and PMI). Details of the complete phase 3 distribution are shown below in table 3:

table **03** Q1 FY19 targets and achievements

Performance Indicators	Estimated Target Q1 FY19	Achievements Q1 FY 19	Achieved
1. Number of LLINs that were distributed in this reported quarter	935,311	1,091,031	117%
2. Number of community health workers trained in counseling on LLIN use in the reported quarter	1,180	1,462	119%
3. Number of households with at least one LLIN for every two people in the reported quarter	314,018	372,589	119%
4. Number of children < 5 covered with an LLIN in the reported quarter	317,610	384,915	117%
5. Number of pregnant women covered with an LLIN in the reported quarter	40,344	60,316	133%

The discrepancy between the proposed targets and the values reached in the different indicators (number of LLINs distributed, number of households covered, number of children under 5 and number of pregnant women covered) can be explained by the fact that all initial estimates made were based on the Population Census of 2014, as well as on data provided by local and traditional authorities. Based on the experience gained from the LLIN distribution in the 12 provinces covered, it has been observed that there was either a negative deviation (as is the case in Moxico, where a larger population was found) or a positive deviation (as verified in Bengo and Lunda Sul, where many mosquito nets remained because of the population decrease). At the end of the mass distribution, the following amount of PMI LLINs remained in each of the three provinces as detailed in table 4:

table **04** Amount of remaining LLINs from the provinces covered during Q1 FY19

Province	# LLIN left over	Following plan for LLIN
Moxico	2,285	Leave at the DPS warehouse, to be used for routine distribution.
Lunda Sul	7,020	Leave at the DPS warehouse, to be used for routine distribution.
Bengo	14, 262	Return to PSM warehouse in Luanda.

Lessons learned

- In the future, DPS must send invitations in a timely manner to organizations and public departments to be a part of mass campaign activities, along with conducting post-distribution follow up with participating organizations.
- Private-sector engagement is an added value, specifically in the case of UNITEL, which supported the campaign by spreading SMS messages on the importance of sleeping under LLINs every night.
- In Bengo, support from DPS/DMS and municipal administrations was strong during campaign activities. Population adherence to the distribution campaign and the presence at distribution points also was massive, coupled with a very high interest in using the nets to prevent malaria.
- Meetings with civil society partners increased support for registration and distribution activities.

1.4 Recommendations for next quarters

Our recommendations will focus on future mass distribution campaigns that the NMCP will implement, since all planned LLIN mass distribution under HFA will be finished during Q2 FY19, and routine distribution will start soon afterwards. Based on HFA's experience gained during the four phases of the mass distribution campaign, the following recommendations are suggested for the NMCP and its partners to consider for future mass distributions:

- A mass distribution campaign strategy must have sufficient time for planning and mobilization of resources, with at least six months recommended.
- Distribution should be avoided during the rainy season.
- Information gathered in micro and macro planning is redundant, and this planning can be combined in a single planning exercise. In turn, this strategy will free up more time for planning and aligning partners' responsibilities at the provincial and municipal levels.
- Training plans should be reviewed to include practical sessions in the community, making it possible for trainers and activists to have direct contact with the environment in which they will work.
- In areas of difficult access or in case of a nomadic population, registration and distribution activities can be combined to facilitate logistical operations and optimization of time, provided there are enough LLINs available in the province.
- Transport should be rented directly in the municipalities where they will work to reduce the number of dropouts and decrease costs.
- The NMCP's information, education and communication and behavior change communication (IEC/BCC) materials should be developed prior to distribution and considered by all partners that are present in each province so they are correctly branded, and also have formal approval from the Ministry of Health (MoH).
- Distribution materials must be pre-positioned at distribution points at least 10 days in advance.
- The NMCP should develop a monitoring and evaluation (M&E) plan with clear objectives for supervision visits to avoid overloading staff who are implementing activities on the ground.

1.5 Proposed Activities for Q2 FY19

LLIN Mass Distribution

During Q2 FY19, HFA will finish the mass distribution campaign in the five remaining municipalities of Lunda Norte (Capenda-Camulemba, Chitato, Xá-Muteba, Cambulo and Cuango), which were not able to be completed by Dec. 21, 2018, as expected. This delay was essentially related to the miscalculations in population and consequent number of LLINs needed for the province of Lunda Norte, which were based on the Population Census and information provided by provincial health authorities and traditional leaders. Additionally, the PSI field operations team encountered communes and localities that were not mapped during registration and distribution activities. Lastly, the requested coverage of a Congolese refugee camp in the municipality of Lucapa also proved to be complicated given its volatile and constantly changing population. Of the initial number of 603,100 expected LLINs to cover Lunda Norte, an additional 62,216 LLINs proved to be needed, with an additional 8,000 LLINs later requested to cover the last municipality of Cambulo, for which coverage is expected to be completed in Q2.

LLIN Routine Distribution

After the mass distribution campaign was finished, HFA was requested to provide technical assistance to the NMCP in the implementation of a Routine Distribution Strategy, which is being developed by VectorWorks under USAID's support. HFA will provide support, which includes the development of a detailed distribution plan for each of the PMI provinces (Zaire, Malanje, Uíge, Kwanza Norte, Lunda Sul and Lunda Norte), a monitoring and supervision plan (on services provided and stock management), and regular reporting of health units (HUs) involved—or those that provide antenatal care (ANC) and Expanded Program on Immunization (EPI) services—to provincial and national health authorities.

In total, HFA's support will be focused on 337 HUs that provide ANC and 324 EPI services in the six PMI provinces. This support will be provided under the NMCP's coordination and in partnership with PSM. Technical assistance also includes the training and supervision of health care providers, supporting the GPS implementation of effective stock management and improving communication with beneficiaries.

Table 5 below shows Q2 FY19 targets for routine distribution:

	Province / municipality	Nº of expected pregnant women in 2019	Nº of expected children < 1 year of age in 2019	% of pregnant women going to ANC	Percentage of children 12-23 months who received Pentavalent 3 vaccine (IIMS 2015-2016 page 159)	LLINs for routine distribution to pregnant women **	LLINs for routine distribution to children < 5 years of age receiving Pentavalent 3 vaccine **	Total LLINs needed for routine distribution	Nº of health units	Nº of health units with ANC services (Source: Reproductive Health Program)	Nº of health units with vaccination services (Source: EPI)
	Kwanza Norte	**13,412**	**23,270**	**77%**	**33.3%**	**9,255**	**7,749**	**17,003**	**127**	**23**	**38**
1	Ambaca	2,016	3507	69%	33.3%	1,391	1,168	2,559	13		5
2	Banga	230	504	69%	33.3%	158	168	326	6		5
3	Bolongongo	330	582	69%	33.3%	227	194	421	9		2
4	Cambambe	3,223	4622	69%	33.3%	2,224	1,539	3,763	25		6
5	Cazengo	4,879	9327	69%	33.3%	3,367	3,106	6,472	31		11
6	Golungo Alto	653	1441	69%	33.3%	450	480	930	10	23	2
7	Lucala	720	1258	69%	33.3%	497	419	916	8		2
8	Ngonguembo	152	289	69%	33.3%	105	96	201	7		2
9	Quiculungo	206	463	69%	33.3%	142	154	296	9		0
10	Samba Caju	1,004	1277	69%	33.3%	693	425		9		3
	Malange	**32,456**	**54,718**	**82%**	**43.9%**	**14,281**	**24,021**	**38,302**	**147**	**53**	**56**
1	Cangandala	1,943	2,652	44%	43.9%	855	1,164	2,019	11		4
2	Cuaba Nzogi	487	551	44%	43.9%	214	242	456	14	53	4
3	Cunda-Dia-Baze	180	337	44%	43.9%	79	148	227	7		1

4	Luquembo	2,139	3,220	44%	43.9%	941	1,413	2,355	6		1
5	Malanje	14,234	25,168	44%	43.9%	6,263	11,049	17,312	40		22
6	Marimba	1,139	1,700	44%	43.9%	501	746	1,248	6		2
7	Massango	1,799	2,174	44%	43.9%	791	954	1,746	8		1
8	Mucari	1,030	1,713	44%	43.9%	453	752	1,205	6		3
9	Quela	901	1,450	44%	43.9%	397	637	1,033	8	53	2
10	Quirima	909	1,245	44%	43.9%	400	547	947	8		2
11	Cacuso	2,448	3,627	44%	43.9%	1,077	1,592	2,669	6		3
12	Cambundi Catembo	1,513	3,627	44%	43.9%	666	1,592	2,258	6		3
13	Cahombo	757	3,627	44%	43.9%	333	1,592	1,925	5		2
14	Calandula	2,978	3,627	44%	43.9%	1,310	1,592	2,902	16		6
	Uíge	**46,472**	**72,217**	**59%**	**25.2%**	**12,548**	**18,199**	**30,746**	**351**	**62**	**100**
1	Buengas	1,655	2,776	27%	25.2%	447	700	1,146	15		5
2	Bungo	1,214	1,885	27%	25.2%	328	475	803	22		4
3	Cangola	2,145	2,931	27%	25.2%	579	739	1,318	14		3
4	Mucaba	169	248	27%	25.2%	46	62	108	16		7
5	Puri	1,060	1,966	27%	25.2%	286	495	782	15	62	4
6	Quitexe	1,062	1,727	27%	25.2%	287	435	722	19		4
7	Sanza Pombo	2,650	3,763	27%	25.2%	715	948	1,664	3		10
8	Ambuila	551	859	27%	25.2%	149	216	365	16		2

9	Bembe	1,063	1,658	27%	25.2%	287	418	705	19		4
10	Damba	2,104	3,279	27%	25.2%	568	826	1,394	26		12
11	Maquela do Zombo	4,047	6,309	27%	25.2%	1,093	1,590	2,683	27		8
12	Milunga	1,593	2,484	27%	25.2%	430	626	1,056	16	62	3
13	Negage	4,483	6,988	27%	25.2%	1,210	1,761	2,971	30		7
14	Quimbele	4,282	6,674	27%	25.2%	1,156	1,682	2,838	17		5
15	Songo	2,063	3,216	27%	25.2%	557	811	1,368	29		8
16	Uíge	16,330	25,454	27%	25.2%	4,409	6,414	10,824	67		14
	Zaíre	**14,370**	**27,532**	**98%**	**54.7%**	**8,047**	**15,060**	**23,107**	**129**	**96**	**60**
1	Cuimba	1,271	2,875	56%	54.7%	712	1,573	2,285	16		10
2	M'Banza Kongo	4,954	9,098	56%	54.7%	2,774	4,977	7,751	32		19
3	Nzeto	935	1,975	56%	54.7%	524	1,081	1,604	19		5
4	Nóqui	725	1,241	56%	54.7%	406	679	1,085	12	96	7
5	Soyo	5,532	10,475	56%	54.7%	3,098	5,730	8,828	31		11
6	Tomboco	952	1,867	56%	54.7%	533	1,021	1,554	19		8
	Lunda Sul	**23,278**	**30,860**	**89%**	**40.1%**	**14,199**	**12,375**	**26,574**	**137**	**68**	**24**
1	Cacolo	776	1,450	61%	40.1%	473	582	1,055	14		5
2	Dala	1,208	1,962	61%	40.1%	737	787	1,524	25	68	4
3	Muconda	2,159	2,526	61%	40.1%	1,317	1,013	2,330	26		4
4	Saurimo	19,135	24,921	61%	40.1%	11,673	9,993	21,666	72		11

table
05
cont

Routine Distribution quantification and projections for FY19

	** Lunda Norte	42,098	53,207	71%	31.2%	10,104	16,601	26,704	116	35	46
1	Cambulo	6,775	8,360	24%	31.2%	1,626	2,608	4,234	21	35	6
2	Capenda Camulemba	3,326	3,878	24%	31.2%	798	1,210	2,008	14		4
3	Caungula	775	1,411	24%	31.2%	186	440	626	15		2
4	Chitato	9,252	12,670	24%	31.2%	2,220	3,953	6,173	15		13
5	Cuango	10,555	11,467	24%	31.2%	2,533	3,578	6,111	13		5
6	Cuílo	441	1,017	24%	31.2%	106	317	423	6		2
7	Lóvua	1,504	1,356	24%	31.2%	361	423	784	1		1
8	Lubalo	628	1,066	24%	31.2%	151	333	483	9		1
9	Lucapa	6,689	8,435	24%	31.2%	1,605	2,632	4,237	13		8
10	Xá-Muteba	2,537	3,546	24%	31.2%	609	1,106	1,623	9		4
	TOTAL					**68,433**	**94,004**	**162,437**	**1,007**	**337**	**324**

1. According to the NMCP guidelines related to LLIN routine distribution, only pregnant women attending ANC and children < 1 year of age receiving the 3rd dose of Pentavalent vaccine are eligible to receive LLINs.

2. The expected number of pregnant women and children < 1 year of age was calculated based on the population registered in each municipality during the LLIN mass distribution campaign.

1.6 Proposed action plan for the next quarter (Q2 FY19)

Result 1: LLIN Access and Use Increased by at least 30%	Jan	Feb	Mar
Routine Distribution			
1. Quantify your need: Given that PSM will be responsible for the procurement of LLINs for routine distribution, work with PSM to ensure that the quantification is accurate.	X		
2. Convene a coordinating committee: Coordinate with entities (governmental and non-governmental) responsible for overseeing ANC and EPI clinics. Include reproductive HUs and routine immunization units (national and provincial) from the MoH in the coordinating committee.		X	
3. Create national and provincial teams: Capitalize on existing supportive supervision or outreach training and supportive supervision.		X	
4. Develop an SBCC plan: Given that ANC attendance is known to be very low, take advantage of networks of activists that have worked during LLIN mass distribution to increase ANC attendance. Social and behavior change communication (SBCC) activities should address identified barriers to ANC attendance.		X	
5. Ensure documentation of LLINs: Ensure LLINs are included in ANC/EPI paper registers and cards, and ANC/EPI modules are included in the District Health Information System 2 (DHIS2).		X	
6. Develop a training plan and conduct trainings: Capitalize on existing malaria and child health trainings.			X
7. Distribute nets: Begin implementation and distribution of nets to beneficiaries.			X
8. **Analyze data and adjust plan based on findings:** Determine how quantification (and procurement) will be adjusted based on changing needs, e.g., if the current quantification was based on low ANC attendance, the current quantification might not be adequate if ANC attendance increases.			X

1.7 SBCC to support LLIN distribution

1.7.1 SBCC Achievements in Q1 FY19

SBCC – malaria jingles

The malaria jingle was developed and approved by the NMCP in Q1 FY19. It was shared with the Secretary of State for Social Communication, Dr. Celso Malavoloneke, for radio placement after two meetings were held with the PSI team and himself in December. Starting in Q2, the spot will air on Radio Nacional, according to the media plan suggested by PSI, which should be adjusted by the Radio Nacional team. After confirming the jingle is on the air, a monitoring plan will be set up.

The Secretary of State, who leads the *Comissão Interministerial para o Combate à Cólera e Malária*, took the initiative of inviting the PSI Marketing & Communication Director to an individual meeting that took place at the Social Communication Ministry on Dec. 7, 2018. This meeting was held to reinforce the intention of involving PSI Angola in the existing technical working group, as well as to highlight that national TV channels and radio stations are willing to distribute health-related content developed by communication experts, especially on malaria and cholera.

SBCC – post-LLIN distribution communication

The remaining SBCC activities for the post-LLIN mass distribution campaign are split between SBCC training and supportive supervision, with specifics shown in table 6 below:

table 06 SBCC activities and specifics

	SBCC Training	Supportive Supervision
In which provinces?	All 13 provinces where the LLIN mass distribution campaign was conducted.	Only 6 PMI provinces. The remaining 12 provinces are the responsibility of the NMCP.
When?	Maximum of 3 months after the campaign has finished.	One month after the SBCC training.
For whom?	Provincial Malaria Supervisors (SPM), Provincial Supervisor for Health Promotion (SPPS), Municipal Malaria Supervisors (SMM) and Municipal Supervisor for Health Promotion (SMPS)	SPM, SPPS, SMM and SMPS, during their training to traditional leaders
Who will deliver the training?	NMCP and HFA	NMCP and HFA

During Q1 FY19, a post-campaign training on communication for behavior change was conducted in five provinces (Kwanza Norte, Malanje, Uíge, Zaire and Huambo), resulting in 120 people being trained, including provincial and municipal malaria supervisors, as well as provincial and municipal health promotion supervisors. Topics covered during the trainings included the following:

- Distribution campaign results
- Importance of communication for behavior change
- Concept of malaria (disease, transmission and prevention)
- The community leader's role in behavior change and the importance of his/her involvement
- Communication strategies

table
07

SBCC achievements during Q1 FY19

Province	Date of Training	# Municipalities	# Trainees					Total
			SPPM	SPPS	SMPM	SMPS	Others*	
Kwanza Norte	Nov. 12-16, 2018	10	1	1	10	9	3	24
Uige	Nov. 19-24, 2018	15	1	2	15	14	0	32
Malanje	Nov. 12-16, 2018	14	1	1	13	11	0	26
Zaire	Nov. 19-24, 2018	6	1	1	6	6	0	14
Huambo	Oct. 29-Nov. 2, 2018	11	1	1	11	11	0	24
Total		54	5	6	55	51	3	120

* Director and group coordinators of volunteer activities (O. V. V) in Kwanza Norte.

In Q2 FY19, HFA will engage in training the Provincial and Municipal Supervisors of Malaria and Health Promotion (SPM, SMM, SPPS and SMPS) in the five remaining provinces covered during phases 3 and 4 of the LLIN mass campaign: Cuando Cubango, Lunda Sul, Lunda Norte, Moxico and Bengo, followed by supportive supervision.

1.7.2 SBCC proposed action plan for Q2 FY19

Result 1: LLIN Access and Use Increased by at least 30%	Jan	Feb	Mar
SBCC			
Training			
1.1 - Post-campaign communication for the promotion and proper use of LLINs in the province of Cuando Cubango. Trainers: Fátima João/NMCP and Alberto Zingany/HFA	X		
1.2 - Post-campaign communication for the promotion and proper use of LLINs in the province of Moxico. Trainers: Fátima João/NMCP and Alberto Zingany/HFA		X	
1.3 - Post-campaign communication for the promotion and proper use of LLINs in the province of Lunda Sul. Trainers: Fátima João/NMCP and Alberto Zingany/HFA		X	
1.4 - Post-campaign communication for the promotion and proper use of LLINs in the province of Lunda Norte. Trainers: Fátima João/NMCP and Alberto Zingany/HFA			X
1.5 - Post-campaign communication for the promotion and proper use of LLINs in the province of Bengo. Trainers: Fátima João/NMCP and Alberto Zingany/HFA			X

1.8 Environmental Mitigation Monitoring Plan for (FY19)

Results 1: LLIN Distribution - Achieved Results Q1 FY19					
	Q1	Q2	Q3	Q4	Total
# of households receiving messages on appropriate use of LLIN	372,589				372,589

2 Result 2: Improved Malaria Services throughout Targeted Municipalities

2.1 Background

At the proposal stage, USAID approved HFA to target 24 priority municipalities in the six PMI provinces, based on: a) municipalities with the largest population density in each province and b) mapping existing activities that NMCP partners implemented from August and September 2016. These selection criteria helped avoid duplication and maximize the resources USAID/PMI made available.

When planning for FY19 activities, the donor asked HFA to scale up the number of target municipalities from 24 to all 60 in the six PMI provinces. Hence, the malaria activities now cover 100% of HUs, which in turn will need training and supervision for all of their health workers (HWs).

As a consequence of the scale up, three essential activities were also extended, focusing mostly on the 36 newly included municipalities that have not been covered in previous years (FY17 and FY18). These three activities are as follows:

- Trainings on malaria case management (MCM) and lab diagnosis (LD), targeting 36 municipalities.
- Formative supervision and on-the-job training consisting of M&E on knowledge and practices of HWs previously trained by the HFA Project in the 24 priority municipalities.
- Integrated community case management (iCCM) implemented by ADECOS, in cooperation with the Support Social Fund (FAS/MAT) and the NMCP/DNSP (National Department of Public Health) in three provinces: Zaire, Lunda Sul and, more recently, Kwanza Norte.

Given that the priority activities under result 2 were training and formative supervision, the annual targets established and approved by USAID for FY19 are as follows:

Performance Indicators	FY19 Targets
1. Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds.	1,129
2. Number of health workers trained in malaria diagnostics with rapid diagnostic tests (RDTs) with USG funds.	1,544
3. Number of health workers trained in malaria laboratory diagnostics (microscopy) with USG funds.	161
4. Number of health workers trained in intermittent preventive treatment in pregnancy (IPTp) with USG funds.	254
5. Number of health workers who received formative supervision on malaria diagnostic in the fiscal year.	320
6. Number of health workers who received formative supervision in ACT use in the fiscal year.	320

Likewise, HFA will continue to provide technical and financial support to the iCCM Strategy with ADECOS in selected municipalities of Lunda Sul and Zaire Provinces, and FAS has requested support for scaling up the ADECOS national policy through training 150 new ADECOS in Zaire, Lunda Sul and Cuanza Norte provinces. HFA will expand support to 90 additional ADECOS in Zaire (Noqui, Cuimba), 30 in Lunda Sul (Cambambe) and 30 in Cuanza Norte (Cambambe and Golungo). As a result, HFA will support 9 municipalities with ADECOS Strategy. For the iCCM activities implemented by ADECOS, HFA defined the following targets for FY19:

	Indicator	FY19 Targets
1	Number of new ADECOS trained in malaria case management at the community level	150
2	Number of ADECOS supervised in malaria case management at the community level	270
3	Number of fever cases reported by ADECOS at the community level	12,782
4	Number of fever cases tested with RDT by ADECOS at the community level	12,782
5	Number of confirmed malaria cases reported by ADECOS at the community level	6,391
6	Number of confirmed malaria cases treated with ACT reported by ADECOS	6,391
7	Number of confirmed malaria cases referred to HUs by ADECOS	639

2.2 Targets and Achievements of Q1 FY19

During Q1 FY19, HFA continued working in close collaboration with its key partners, including the National Directorate of Public Health (DNSP), the NMCP, the provincial and municipal health directorates, the Global Fund, the WHO and the PSM project. In cooperation with these partners, HFA was able to accomplish the following results described in table 8:

table **08** Results achieved by key indicators

Key Indicators	FY18 targets	FY19 Results Achieved					% Achieved
		Q1	Q2	Q3	Q4	Total	
1. Number of HWs trained in case management with ACT with USG funds.	1,129	274				274	**24.3%**
2. Number of HWs trained in malaria diagnostics with RDTs with USG funds.	1,544	409				409	**26.5%**
3. Number of HWs trained in malaria laboratory diagnostics (microscopy) with USG funds.	161	30				30	**18.6%**
4. Number of HWs trained in intermittent preventive treatment in pregnancy with USG funds.	254	105				105	**41.3%**
5. Number of HWs who received formative supervision on malaria diagnostics (rapid diagnostic test or microscopy).	444	132				132	**29.7%**
6. Number of HWs who received formative supervision in ACT use.	444	132				132	**29.7%**

Source: M&E HFA Project

2.2.1 Trainings in malaria case management and lab diagnosis

HWs trained in case management with artemisinin-based combination therapy:

To achieve malaria control objectives, appropriately planned and targeted delivery of essential malaria interventions is critical, including early diagnosis by testing suspect malaria patients and prompt treatment of confirmed cases with effective artemisinin-based combination therapy (ACT)[1]. Under the coordination of and close collaboration with the NMCP, HFA conducted HW trainings in Q1 FY19 as follows:

table **09** Health workers trained in ACT by province and sex

Provinces	Target FY2019	Q1			Q2			Q3			Q4			Total			% (Achieved / Target)
		M	F	Total	M	F	T	M	F	T	M	F	T	M	F	Total	
Kwanza Norte	169	35	20	55										35	20	55	32.5%
Lunda Norte	140	0	0	0										0	0	0	0.0%
Lunda Sul	105	15	16	31										15	16	31	29.5%
Lunda Sul	215	58	27	85										58	27	85	39.5%
Uíge	382	25	32	57										25	32	57	14.9%
Zaire	118	27	19	46										27	19	46	39.0%
Subtotal	**1,129**	**160**	**114**	**274**										**160**	**114**	**274**	**24.3%**

Source: M&E HFA Project

Results show that a total of **274** HWs (41.6% female and 58.4% male) were trained in MCM, with skills to prescribe ACT.

These trainings were facilitated by MoH national certified trainers from national and provincial levels, selected by the NMCP.

HWs trained in intermittent preventive treatment in pregnancy

The Ministry of Health (MOH) of Angola has adopted this recommendation, but it is stated that to reduce the risks of pregnant women getting malaria, the current policy under the NMCP calls for all pregnant women to receive *at least* 4 doses of SP, at a minimum of one month apart after quickening[2], and the Angolan Government had adopted this

[1]Training module on malaria control: case management. World Health Organization. 2012

standard as well. The risk associated with the occurrence of malaria during pregnancy is high in Angola. Like many other countries with a high burden of malaria, Angola has national strategies in place that include the prevention of malaria among expectant women. The Angola MoH has adopted the WHO's recommendation, which states that to reduce the risk of getting malaria, all pregnant women must receive at least four doses of sulfadoxine-pyrimethamine (SP), at a minimum of one month apart after quickening[3].

During Q1 FY19, in partnership with and under the coordination of the NMCP, HFA conducted HW trainings and achieved the following results:

table **10** Health workers trained in intermittent preventive treatment in pregnancy by province and sex

Provinces	Target FY2019	Q1			Q2			Q3			Q4			Total			% (Achieved / Target)
		M	F	Total	M	F	T	M	F	T	M	F	T	M	F	Total	
K. Norte	36	1	16	17										1	16	17	47.2%
L. Norte	37	5	11	16										5	11	16	43.2%
L. Sul	31	3	16	19										3	16	19	61.3%
Malanje	59	9	28	37										9	28	37	62.7%
Uíge	63	0	o	0										0	0	0	0.0%
Zaire	28	11	5	16										11	5	16	57.1%
Subtotal	**254**	**29**	**76**	**105**										**29**	**76**	**105**	**41.3%**

Source: M&E HFA Project

[2]República de Angola. Ministério de Saúde. Direcção Nacional de Saúde Pública. Programa Nacional de Controlo da Malária. Manual de Prevenção e Tratamento da Malária Durante a Gravidez. Luanda, Angola. Segunda Edição. 2017. WHO guidelines from 2018 recommends 3-4 doses of SP.

[3]República de Angola. Ministério de Saúde. Direcção Nacional de Saúde Pública. Programa Nacional de Controlo da Malária. Manual de Prevenção e Tratamento da Malária Durante a Gravidez. Luanda, Angola. Segunda Edição. 2017. WHO guidelines from 2018 recommend three to four doses of SP.

Results show that 105 HWs (72.4% female and 27.6% male), including doctors, nurses and midwives, were trained in MCM and had skills on ANC services for prescribing SP as intermittent preventive treatment in pregnancy (IPTp) to pregnant women. MoH-certified trainers selected by the NMCP facilitated the five days of training sessions.

HWs trained in malaria laboratory diagnostics (optic microscopy) and rapid diagnostic tests

Conventional microscopy is the established method for laboratory confirmation of malaria. Careful examination by an expert microscopist of a well-prepared and well-stained blood film currently remains the "gold standard" for detecting and identifying malaria parasites. Another important diagnostic method currently used is the rapid diagnostic test (RDT), which is based on the detection of antigens derived from malaria parasites in lysed blood, using immune chromatographic methods. Both methods are critical to ensuring that early diagnostic testing of malaria happens before treatment is provided. During Q1 FY19 under coordination of the NMCP, HFA conducted trainings of laboratory technicians and achieved the results detailed in Table 11:

table 11 | Lab technicians trained in laboratory diagnosis (OM and RDT) by province and sex

Provinces	Target FY2019	Q1			Q2			Q3			Q4			Total			% (Achieved / Target)
		M	F	Total	M	F	T	M	F	T	M	F	T	M	F	Total	
Kwanza Norte	37	9	9	18										9	9	18	48.6%
Lunda Norte	34	0	0	0										0	0	0	0.0%
Lunda Sul	12	0	0	0										0	0	0	0.0%
Lunda Sul	34	6	6	12										6	6	12	35.3%
Uíge	32	0	0	0										0	0	0	0.0%
Zaire	12	0	0	0										0	0	0	0.0%
Subtotal	**161**	**15**	**15**	**30**										**15**	**15**	**30**	**18.6%**

Source: M&E HFA Project

Results show that **30** laboratory technicians (50% female and 50% male) attended a 10-day training on Laboratory Diagnosis of Malaria, through Optic Microscopy (OM) and RDT in Q1 FY19. The training sessions were carried out in Kwanza Norte and Malanje provinces by MoH national certified trainers, selected by the NMCP.

HWs trained in malaria diagnose with RDTs

HFA assumes that every HW trained in MCM (ACT, IPTp and OM) is also trained in the use of RDT. The NMCP curricula and training plans include specific sessions on malaria diagnosis with RDT. The HFA target for FY19 is **1,544** HWs to be trained on RDTs, and the result achieved in Q1 FY19 was **409** HWs trained on RDTs, which means 26.5% of the target reached so far. During Q1 FY19, under coordination of the NMCP, HFA conducted HW trainings as follows:

table **12** Health Workers trained in RDTs by Province and Sex

Provinces	Target FY2019	Q1			Q2			Q3			Q4			Total			% (Achieved / Target)
		M	F	Total	M	F	T	M	F	T	M	F	T	M	F	Total	
Kwanza Norte	242	45	45	90										45	45	90	37.2%
Lunda Norte	211	5	11	16										5	11	16	7.6%
Lunda Sul	148	18	32	50										18	32	50	33.8%
Lunda Sul	308	73	61	134										73	61	134	43.5%
Uíge	477	25	32	57										25	32	57	12.0%
Zaire	158	38	24	62										38	24	62	39.2%
Subtotal	**1,544**	**204**	**205**	**409**										**204**	**205**	**409**	**26.5%**

Source: M&E HFA Project

In summary, during this reporting period (Q1), HFA trained **274** HWs in ACT (Table 9), **105** HWs in IPTp (Table 10) and **30** HWs in Optic Microscopy (Table 11), totaling **409** HWs trained. By gender, results show that 49.9% of the trained HWs were male **(204)** and 50.1% female **(205)**.

2.2.2 Formative supervision

During Q1 FY19, formative supervision consisted of M&E on the knowledge and practices of HWs, according to national guidelines from the NMCP/DNSP on the correct use of RDTs, treatment with ACT and appropriate administration of IPTp in antenatal clinics.

Formative supervision methodology

The methodological approach of supervision activities is a quick assessment of HWs' knowledge and ability to handle MCM. Supervision activities were conducted using a checklist tool comprised of three sections representing the health areas supervised as follows: 1) ANC services (malaria in pregnancy-MiP); 2) pediatrics; and 3) adult medicine and the emergency room, with evaluation conducted through observing key aspects of malaria diagnosis and timely treatment of patients.

In each province, HFA formed one supervision team composed as follows: 1) the provincial malaria official (OPM), 2) the provincial official for the malaria program (OPPM) and 3) a third member who is being trained as a supervisor. The objective is that all HWs trained should be supervised by someone from the provincial and municipal level while services are provided, including during patient care.

At the end of each supervision activity, the supervisors conduct a short meeting with each HW who is supervised, which provides feedback regarding compliance with national and other norms and protocols, their difficulties, and any work-related challenges. At the same time, the supervisors list their findings and observations during the services provided by the HW and discuss solutions and best practices for overcoming any issues.

During Q1 FY19, under the coordination of the NMCP, HFA supported formative supervisions as follows:

table **13** Health workers supervised in malaria case management by province and sex

Provinces	Target FY2019	Q1			Q2			Q3			Q4			Total			% (Achieved / Target)
		M	F	Total	M	F	T	M	F	T	M	F	T	M	F	Total	
Kwanza Norte	65	0	0	0										0	0	0	0%
Lunda Norte	46	0	0	0										0	0	0	0%
Lunda Sul	51	0	0	0										0	0	0	0%
Malanje	85	0	60	0										0	60	0	0%
Uíge	127	28	78	106										28	78	106	83.4%
Zaire	70	11	15	26										11	15	26	37.1%
Total	**444**	**39**	**93**	**132**										**39**	**93**	**132**	**29.7%**

Source: M&E HFA Project

Results show that a total of **132** health workers (29.5% male and 70.5% female) were supervised through direct observation of their knowledge and good practices in MCM (ACT, IPTp) and malaria diagnosis with RDTs. During Q1, 58 health units were supervised: 45 in Uíge and 13 in Zaire.

2.2.3 Implementation of iCCM (ADECOS):

During Q1 FY19, HFA supported the Social Support Fund (FAS/MAT) and the NMCP/DNSP in the implementation of the National Program of ADECOS (PNADECOS) for MCM at the community level. According to a new approach that will be implemented during FY19, HFA intends to strengthen malaria services at the HUs to which ADECOS refer their beneficiaries (families covered by each ADECOS in the community). Through mentoring strategies, trained HWs at the reference HUs will contribute to strengthening ADECOS performance, aiming to reduce child morbidity and mortality in Angola caused by three major diseases: diarrhea, pneumonia and malaria. As part of this new approach, the following activities were implemented in Q1 FY19:

- HFA provided technical support and resources to FAS to implement formative supervision activities at the existing 120 ADECOS (60 in Lunda Sul and 60 in Zaire), helping improve the quality of work related to malaria diagnosis, treatment and data collection.
- In coordination with the NMCP and FAS in the Zaire and Lunda Sul provinces, HFA started formative supervision activities in ADECOS referral HUs to strengthen the link between HUs and ADECOS, as well as assure that HWs follow up on ASAQ/RDT stock control.
- HFA supported preparatory activities and coordination to implement the ADECOS expansion in two municipalities in Zaire (Cuimba and Noqui), one municipality in Lunda Sul (Muconda), and the expansion to Kwanza Norte province where two municipalities (Quiculungo and Cambembe) will be joining the program.

Additionally, HFA procured and provided the necessary materials and equipment (computers for supervisors, monitoring forms, smartphones, etc.) for ADECOS and supervisors for their fieldwork. To facilitate the ADECOS implementation, HFA supported the distribution of supplies and materials, including RDT kits and ACTs (ASAQ 25mg/67.5mg, 50mg/135mg and 100mg/270mg, paper log forms for registering stock materials and program indicators) to ADECOS and referral HUs. The services ADECOS provided during Q1 FY19 in Lunda Sul and Zaire provinces are detailed below in Table 14:

table **14** ADECOS performance in Lunda Sul, Zaire and Kwanza Norte provinces

#	Indicator	FY19 Target	Q1	Total	% Achieved
1	Number of new ADECOS trained in malaria case management at the community level	150	0	0	**0%**
2	Number of ADECOS supervised in malaria case management at the community level 3	270	120[54]	120	**44.4%**
3	Number of fever cases reported by ADECOS at the community level[43]	12782	3,505	3,505	**27.4%**
4	Number of fever cases tested with RDT by ADECOS at the community level	12782	3,505	3,505	**27.4%**
5	Number of confirmed malaria cases reported by ADECOS at the community level	6391	1,855	1,855	**29.0%**
6	Number of confirmed malaria cases treated with ACT reported by ADECOS	6391	1,855	1,855	**29.0%**
7	Number of confirmed malaria cases referred to health units by ADECOS	639	401	401	**62.7%**

Source: M&E HFA Project

[43]All data available was collected by the HFA monitoring team, together with MINSA and FAS provincial supervisors.

[54]HFA provided technical support and resources to supervise 120 ADECOS (100%) that currently provide services at the community level. Supervision activities for the 150 new ADECOS will start after implementation in the five new municipalities.

2.3 Constraints and Solutions

2.3.1 Malaria case management:

The main constraint faced in MCM during Q1 FY19 was:

- **Lack of agreement about the facilitators selected for MCM trainings.** During Q1, HFA faced some challenges due to the lack of agreement with the NMCP on the selected trainers who would conduct the trainings with HWs in each of the six PMI provinces. The key issue is that trainers selected by the NMCP had not been trained in pedagogic and adult training techniques at the government-run National Center for Training of Trainers (CENFOR), a decision that negatively affects the quality of the trainings. To overcome this challenge and guarantee training quality, HFA formed trainer pairs, with one participant trained and one participant not trained by CENFOR.

2.3.2 Formative supervision

The main constraint faced at the beginning of implementing formative supervision was:

- **Cumbersome supervision guides.** As mentioned in previous quarterly reports, the supervision guide developed and used by the NMCP is long and cumbersome, with many sections that need to be filled in, resulting in supervisors spending almost two to three hours to complete just one form. These supervision guides are being reviewed and updated, in partnership with the NMCP, and should be ready for use in the next supervision stages. HFA developed a much shorter and user-friendly proposal for MCM, which can be used during formative supervision, once it's approved by the NMCP. A similar proposal is being developed for lab supervision and will be discussed during a workshop with lab technicians in Malanje in Q2. Both proposed supervision guides are being shared and discussed with the NMCP officials.

2.3.3 ADECOS implementation

Since the beginning of implementing the ADECOS program at the community level, several main constraints have been faced:

- **Poor coordination between MOH and FAS/MAT, especially at provincial level:**

- Lack of monitoring and supervision of ADECOS and reference HUs by provincial and/or municipal malaria supervisors. Proper monitoring and supervision would assist in strengthening the link between HWs and ADECOS. HWs from the reference HUs still do not recognize ADECOS for their malaria activities and, therefore, do not participate in providing any support to ADECOS regarding MCM in the community. HWs also do not provide patient referral registers to ADECOS.

- Referral HUs' are lacking in mentoring HWs on stock management to assure stock control and allow for better decision making in material distribution (e.g. ASAQ/RDT).

- **Low performance supervision of ADECOS by FAS:**

- Lack of adequate transportation for supervisors. Motorbikes promised to supervisors have not yet arrived, thus compromising supervisory activities with ADECOS.

- ADECOS supervisors are facing difficulties in reaching certain HUs and micro areas in the most remote places where the roads are in very bad condition.
- Municipal administrations do not have an aligned financial plan for the current fiscal year for supporting supervisors with transport and other expenses (e.g., incentives and meal subsidies), which are necessary to support ADECOS in their micro areas.
- **Recurring issues with the collection and processing of information gathered by ADECOS:**
- Supervisors lack computers to collect information from ADECOS and produce their monthly reports.
- Lack of Internet for uploading data collected by ADECOS into the KoboCollect platform.
- In some micro areas in Lunda Sul, FAS has not yet delivered smartphones to ADECOS since their training. This delay is due to FAS preparing a training workshop.
- A final agreement is lacking between FAS and the NMCP/HFA on the applications (software) used for collecting information from the ADECOS. While FAS uses a KoBoCollect app to collect and transfer data into the Open Data Kit (ODK) system (MAT's information system) in some provinces, HFA has developed a similar KoBoCollect app as an alternative to transfer data into ODK and, at the same time, be compatible with the District Health Information System 2 (DHIS2), the MoH's information system. However, FAS has not yet approved this alternate solution, as results are pending from the pilot in Zaire province.
- **Lack of materials and basic equipment under FAS responsibility:**
- In some areas, ADECOS lack backpacks to carry their key fieldwork kit and materials.
- Lack of latex gloves, which are essential for ADECOS to safely collect blood from patients for RDTs.

2.4 Recommendations for next quarters:

2.4.1 Improve communication and coordination with the NMCP:

- **Hold quarterly coordination and evaluation meetings:** As a mechanism for improving coordination and communication, the NMCP and HFA should hold regular meetings (every quarter in a different PMI province). The objective of such meetings would be to coordinate and evaluate the implementation of malaria activities in the province hosting the meeting. This strategy allows for improved communication and helps avoid challenges and delays in agreements between partners.

2.4.2 Improve the formative supervision methodological approach and tools:

- **Improve supervision methodology and tools:** To enhance the effectiveness of formative supervision and in close collaboration with the NMCP, HFA is reviewing the methodology and guides being used in regular supervision activities and adapting them to the new approach. This new approach focuses on mentoring and coaching as the primary tools for developing HWs' capacity. HFA will take advantage of this process to also review and update available job aids to support the performance of HWs at the HU level.

- **Training health workers:** To cover the health personnel of all municipalities in the six PMI Provinces, HFA should focus efforts and resources on training HWs from the 36 newly included municipalities, and gradually expand the formative supervision approach already being used with previously trained HWs from the 24 priority municipalities to these new municipalities.

2.4.3 Support the implementation and expansion of ADECOS (iCCM strategy):

- Improve coordination between MoH and FAS: To improve the coordination of activities being implemented under the ADECOS program, HFA proposes to:
    - Hold regular meetings with OPMs, SPPMs, OPPMs, provincial Heads of Departments of Public Health and the Central-level Coordination Team (NMCP).
    - Regularly share ADECOS reports with FAS, Provincial Directorates of Health (GPS) and the NMCP.
- Improve supervision of ADECOS: To help supervisors more effectively supervise ADECOS, HFA will ensure that procurement processes and distribution plans are efficiently carried out, improving the availability of and access to materials and equipment, such as motorbikes, portable computers and smartphones.
- Improve data collection and processing: In close collaboration with the NMCP, HFA will continue advocating with FAS to reach a feasible solution regarding data collection and management of the ADECOS statistics that fulfill the expectation of both partners to link the KoBoCollect app with ODK and DHIS2. Additionally, HFA will ask FAS to deliver the smartphones to ADECOS in Lunda Sul province.
- Manage commodities: HFA is coordinating actions with the PSM project (USAID partner) to start a capacity building process to improve the management of commodities (distribution, storage and control) of stock used by ADECOS (RDT, ACT) and referral HUs.

2.5 Environmental Mitigation Monitoring plan:

table **15** Environmental mitigation and monitoring plan for malaria case management

Key Indicators	Achieved results				
	Q1	Q2	Q3	Q4	Total
# of TOTs trained on lab waste management	0				0
# of HWs trained in waste management	409				409
# of ADECOS trained in waste management	0				0
# of bio waste boxes provided to ADECOS	0				0
# of Therapeutic Efficacy Study (TES) study personnel trained in waste management	N/A				

MALARIA

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

5.1 Background

Under Result 5, the Health Information System Strengthening (HISS) was defined as covering two main topics, which have been prioritized:

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

5.2 Summary of Achievements in FY18

During FY18, HFA supported the MoH in implementing and expanding DHIS2 as the national health information system, with a series of corresponding activities carried out:

- Coordinated a four-day workshop to develop the National DHIS2—Open Logistics Management and Information System (Open-LMIS) roadmap.
- Coordinated a three-day workshop to lay the groundwork for interoperability between DHIS2—Open Logistics Management and Information System (Open-LMIS) and other health information systems.
- Implemented and expanded DHIS2 in the six PMI provinces: Uíge, Zaire, Kwanza Norte, Malanje, Lunda Norte and Lunda Sul. This work included the following:
    - 60 municipalities covered.
    - 66 computers distributed (20 donated by World Bank and 46 donated by USAID).
    - More than 280 people trained (246 at the municipal level, 34 at the provincial level and two from Gabinete de Tecnologia e Informacao (GTI)/MoH.

- Data entry of malaria forms from January–June 2018, corresponding to a 66.1% reporting rate (vs. 1.9% in non-PMI provinces) measured on Nov. 8, 2018.
- Six HFA DHIS2 –IT staff permanently deployed in the field (one per province).
- Training materials developed, including creating user and supervisor manuals and configuring MoH-approved malaria forms.

Additionally, in FY18, HFA reached over 100% of its annual targets:

- Trained MoH staff in DHIS2 in the 60 municipalities in the six PMI provinces (282 / 278 = 101.4%);
- Completed the DHIS2 reporting rate from July-September 2018, measured in November 2018 (70.6% / 70.0% = 100.1%).
- Participation of municipal authorities in the health management information system (HMIS) data analyses (45 / 43 = 104.7%).

5.3 Targets and Achievements of Q1 FY19

DHIS2

HFA's work in FY19 will focus on supporting the MoH in improving data quality and data use for decision making within DHIS2. This work follows on FY18's work in implementing and expanding DHIS2 in the six PMI provinces.

In Q1, HFA conducted various activities on routine supervision, data analyses and technical assistance that are summarized in table 21 below. Overall, results show there have been many achievements toward targets for indicators: 94.6% of HUs were updated in the DHIS2 organizational tree, 72.5% of DHIS2 malaria quarterly reports were submitted on time (versus 5.2% in non-PMI provinces), and 78.4% of expected municipal authorities were meeting quarterly to analyze DHIS2 data (40 out of 51 expected).

While other indicators show lower achievements, they are making progress toward the annual target and can be expected to increase as the year progresses. For these indicators, 40.5% of historical malaria data (for calendar year 2017) were entered into the platform (versus 2.6% in non-PMI provinces). Additionally, 16.7% of quarterly data revision meetings expected in the year were held, and 20% of quarterly meetings expected in the year led by NMCP officials were held.

table
21

Health systems strengthening results for FY19 targets

Indicators	FY19 Target for 6 PMI Provinces	Achievement Q1	% Achieved Q1 / Annual Target	Non-PMI Provinces (for comparison only, when applicable) ψ
1. % of health units updated in the organizational DHIS 2 tree	100.0%	94.6%	99.9%	N/A
2. % of DHIS2 malaria quarter reports submitted	85.0%		94.6%	5.2%
3. % of historical data (2017) entered in DHIS2 for 6 PMI provinces, in non-PMI provinces β	85.0%	40.5%	47.6%	2.6%
4. # of municipal authorities meeting quarterly to review DHIS2 data and provide feedback*	> 51	40	78.4%	N/A
5. # quarterly data consolidation / revision meetings **	24	4	16.7%	N/A
6. # of quarterly meetings in which NMCP officials lead DHIS2 analyses for decision making **	> 20	3	20.0%	N/A
7. # of supervision visits implemented to DMS by HFA-MoH personnel ***	> 528	89	16.9%	N/A
8. # of Health Information Systems Inter-Operable with DHIS2	2 (OpenLMIS, KoboCollect)	In progress	N/A	N/A
9. # of MoH staff trained or refreshed (at the national and provincial levels)****	56	N/A (To start in Q2-Q4)	N/A	N/A

ψ Reporting values for Non-PMI provinces on selected indicators will depend on MOH (GEPE-GTI) facilitating such information to HFA.

N/A: Not applicable because activity might not be happening in Non-PMI provinces or not under control of HFA to collect evidence data

β Measured in January 2019.

* Calculated as the total number of municipalities per 85% (60 x 0.85=51). It counts the number of municipalities represented in the meetings, since there is always more than 1 person per municipality attending the meetings and the precise number varies due to different factors. For Q1 FY19, 40 municipalities were represented with a total of 90 participants: 79 at the municipal level and 21 at the provincial level.

** It assumes that 6 provinces x 4 quarterly meetings per province = 24 meetings along the year. It also assumes that out of this total, NMCP staff will lead / participate in at least 80% of the meetings (24 meetings x 80% = 20).

*** 528 supervisions to DMS assumes that at least 80% of 60 municipalities are visited by HFA-MOH personnel every month to check that no problems exist with DHIS2. It also assumes such supervisions take place along 11 months a year. 80% x 60 municipalities x 11 months = 528.

**** It assumes 20% of currently trained personnel in 6 PMI provinces will need refreshment or will be substituted by new personnel that need training (20% x 280 MOH staff = 56 staff to be [re] trained or receive on job coaching).

Routine supervision to the Municipal Health Directorates (Direcção Municipal de Saúde)

This activity started in FY18 and will continue throughout FY19. As expressed in previous reports, HFA and MoH staff conduct routine supervision to assure that recent and historical paper-based forms are inserted into DHIS2 correctly, to periodically update the list of HUs and to provide IT maintenance. The results of routine supervision are expressed in the relatively high reporting rates, as shown in table 22 below. For example, reporting rates for different periods in 2018 were close to or above 70% in the six PMI provinces, compared to less than 7% in non-PMI provinces. For historical data, the MoH started entering data for 2017 in Q1 FY19, with results already showing a 39.8% reporting rate in PMI provinces (versus less than 4% in non-PMI provinces).

table 22 Malaria Reporting Rates for Different Time Periods in 6 PMI Provinces versus Non-PMI Provinces DHIS2

Province	Malaria Reporting Rates (measured in January 2019)			
	Jan – Dec 2017	Jan – Jun 2018	Jul – Sep 2018	Oct – Dec 2018
Zaire	25.5%	89.7%	95.7%	94.3
Lunda Sul	37.0%	59.1%	69.0%	79.1
Malange	36.9%	67.7%	75.1%	75.4
Kwanza Norte	43.2%	70.4%	79.2%	75.3
Lunda Norte	2.4%	66.1%	70.3%	69.2
Uige	54.5%	67.1%	73.1%	63.3
Total PMI Provinces	**39.8%**	**69.0%**	**75.9%**	**72.5**
Total Non PMI provinces	**3.4%**	**6.1%**	**5.05%**	**5.2**
National Average	14.3%	24.9%	26.2%	25.3

Data analysis meetings with municipal and provincial health staff

This activity aims to improve data quality and the skills of MoH staff in data analysis for decision making. It started in FY18 and will continue throughout FY19. Led by the NMCP Monitoring and Evaluation Officers, Dr. Fernanda Guimaraes and Dr. Arlette Troco, and by the HFA Malaria Adviser, Yava Ricardo, this one-day workshop took place in four provinces from October-December 2018. Provinces covered so far are Lunda Sul and Lunda Norte (visited for the first time for this workshop), Uíge and Kwanza Norte (visited for the second time after the first visit in Q4 FY18), and Malange and Kwanza Sul. As in previous quarters, participants in the workshop included an average of two staff members from the municipal level and two staff members from the provincial level (municipal chief and municipal statistician, provincial malaria supervisor and provincial statistician). Results were similar to those in provinces visited in Q4 FY18. Table 23 below lists problems and adds actions taken to solve them in Q1 FY19. An additional step taken in FY19 was to present and discuss the results at a meeting organized by the NMCP in November 2018, with staff members from the Centers for Disease Control and Prevention (CDC) in Atlanta, GA, USA and different MoH departments, including GEPE, the Studies, Planning and Statistics Office (*Gabinete de Estudos, Planearão e Estatística*); the Department of Sexual and Reproductive Health; Epidemiologic Surveillance; and the Department of Public Health.

table 23

Summary from data analyses meetings with municipal and provincial staff to improve data quality and data use for decision making

Level	Problem Encountered (Q4 FY18 & Q1 FY19)	Proposed Action (Q4 FY18 & Q1 FY19)	Actions Taken (Q1 FY19)
Health Units	• Delayed reports to municipalities due to bad road conditions and the type of contract of HU employees (not receiving payment for months) and unwilling to work.	• HFA staff and malaria municipal / provincial supervisors will visit HUs within their routine supervision (to improve registration and submission).	• Preparation of Agenda and Curricula for the Training of 6 HFA staff on HU forms and monitoring processes to start supervision with the MoH staff. Training took place in early January 2019.
Municipal Level	• Lack of electricity (generators are off when DHIS2 data should be added). • Poor Internet access in some municipalities. • DHIS2-trained staff not being paid regularly and on a non-permanent contract.	• Present this situation to GEPE and MOH to discuss it at higher level (electricity problems and contractual situation of employees). • HFA staff will use their modems to upload data into the cloud. Alternatively, municipalities with internet problems will go to areas with good internet coverage to upload information, while the situation is resolved with UNITEL.	• The electricity problem was presented to GEPE and NMCP. Action needs to be taken. • UNITEL and HFA tested the DHIS2 platform to assure that no "air time" is consumed when data is uploaded. Fixed in most cases, but testing continues. • HFA bought 30 modems of alternative brand in Q1 and will distribute them in Q2 to municipalities in more need
DHIS2 Level	• Need to update HUs in DHIS2. • Electronic sheets of some programs are not always linked with DHIS2. • Electronic sheets sometimes have errors in formulas (reproductive health and contraceptive stock levels). • Lack of sufficient number of modems in all provinces due to stock out in the country and UNITEL.	• HFA staff and malaria municipal and provincial supervisors will continue updating the HU map and submit it to GEPE for an upgrade (currently, GEPE is responsible for updating the HUs under DHIS2). • HFA staff and GTI will continue identifying forms not linked to HUs or with configuration problems, working on solutions. A WhatsApp DHIS2 group exists to report these problems. • HFA has requested UNITEL to import modems for future distribution to the municipalities.	• GTI/GEPE and HFA have updated HUs under DHIS2. This work needs to be done on a regular basis. • Electronic sheets have been linked to HUs. • Formulas have been revised per request (on going work). • UNITEL continues to have problems importing modems, so HFA bought 30 modems of alternative brand in Q1 to be distributed in Q2.

table 23 cont

Summary from Data Analyses Meetings with Municipal and Province Staff to Improve Data Quality and Data Use for Decision Making.

Data Analyses	• Incoherence of data reported by some health units: # of patients tested with RDT versus # of RDT used; # of LLIN distributed versus # of beneficiaries. • Difference in data reported using the NMCP form vs. epidemiological surveillance (malaria cases and deaths) or SRH (IPTp). • Some data inputted were out of the feasible range, e.g., 13 million tested cases with RDT by a HU in Kwanza Norte.	• HFA staff and municipal / provincial malaria supervisors will visit HUs to improve quality of data registration. • HFA, GEPE and the NMCP will continue reinforcing the need for municipal health area supervisors (malaria, epidemiological surveillance, reproductive health) to jointly revise data from their different forms before data entry in DHIS2.	• Planned training for HFA IT staff on HU forms and monitoring processes in Q2. This training will take place in early Q2, with fieldwork to follow. • Validation rules were revised, and current errors corrected. Continuous work will be done as problems are identified and reported by users.

Angolan Ministry of Health increased endorsement of DHIS2

Expansion of DHIS2 in the six PMI provinces has attracted the attention of the Minister of Health, to the extent that she has requested HFA staff to support the MoH in several additional activities:

- Training on DHIS2 relevance and use for decision making to directors of different MoH Departments (NMCP, Public Health, Reproductive Health, Epidemiological Surveillance, etc.) in October 2018.
- Analyze DHIS2 data for the MoH's annual budget plan in January 2019.

The Minister of Health has also requested that provincial governors adopt and start reporting data using DHIS2, starting in Q1 FY19. HFA was also informed that the Minister of Health signed a Memorandum of Understanding (MoU) with UNITEL that will provide free access to upload data into DHIS2 without cost, and this MoU was pending for several quarters.

Monitoring activities with the NMCP/MoH

During Q1 FY19, the HFA M&E Adviser supported the NMCP on a wide range of activities, with the most relevant as follows:

- DHIS2 data quality and data analyses meetings in four provinces (Kwanza Norte, Lunda Norte, Lunda Sul and Uíge) from October to December 2018.

- Continued technical support in the revision of the Global Fund Concept Note on Health Systems Strengthening in October 2018.
- Held a NMCP working session with MoH Departments (NMCP, GEPE, Epidemiological Vigilance, Reproductive Health, and Tuberculosis) to present and discuss the DHIS2 data quality and analyses report in November 2018.
- Conducted monthly analysis of malaria epidemiological data with the NMCP M&E team from October to December 2018.
- Technical support in the development of the Malaria Control Operational Plan for Southern Angola in November 2018.
- Curricula development to train MoH focal points on the Malaria Early Warning System (MEWS) in four epidemic-prone provinces (Cunene, Cuando Cubango, Huila and Namibe) in December 2018.
- Technical support in revising and updating the 2019 Malaria Commodities Plan in December 2018.
    - Participation in technical meetings with the NMCP/DNSP, e.g., "crisis room", meetings with the Global Fund, Elimination 8, etc., which is ongoing.

Research activities

- **Therapeutic Efficacy Study:** For this therapeutic efficacy study (TES), the procurement of materials and equipment was initiated in November 2018; a meeting with CDC staff to discuss the implementation strategy was held on December 10, 2018; and the Institutional Review Board (IRB), also known as the independent ethics committee, gave approval to the CDC and Angola in January 2019. Training and fieldwork are planned for the end of January and beginning of February 2019.
- **LLIN Use and Care Study:** The study design and tools were developed and presented to the NMCP coordinator for feedback in November 2018. The study was submitted to both PSI and the Angola Ethics Committees (IRB) in December, and respective approvals were received the same month and in January 2019, respectively. The agency in charge of conducting fieldwork was selected through a competitive process that started in October and ended in December 2018. The study was submitted to the Johns Hopkins University (JHU) ethics committee on Jan. 28, 2019. The JHU ethics committee is expected to give its approval by the second or third week of February 2019, and fieldwork will start soon afterwards.
- **Operational Research (OR): Southeast Asian Migrant Study:** The study design was submitted to the Angolan IRB in December 2018, after presenting the study to the NMCP coordinator and incorporating his feedback in November 2018. PSI also shared a letter to be signed by the CDC IRB team, in which PSI cedes the IRB process to the CDC. The letter was sent in November 2018. That process is still pending, as the letter needs the CDC's signature when returned to PSI. The Angolan IRB has not yet granted approval. Follow up will be done with both IRB teams.

5.4 Constraints and Solutions

- Continued lack of modems in the market to connect to the DHIS2 platform. As documented in previous reports to USAID, modems continue to be out of stock in Angola. In Q1 FY19, around 30 municipalities experienced problems to upload information immediately after data entry. To solve this problem, HFA staff visited those municipalities and momentarily lent their modems or coordinated frequent visits to assist the municipalities with modems, with the main purpose of connecting to the net and uploading information to DHIS2. By December 2018, HFA found in the market and purchased 30 modems of an alternative brand to UNITEL. Distribution to the municipalities will start in January 2019. HFA will continue looking for modems of the best brand in order for municipalities to connect to the DHIS2 platform.

- **Large number of municipalities to be routinely supervised.** Although the allocation of one HFA staff member in each of the six PMI provinces has shown positive results in solving daily problems with DHIS2, which is reflected in an increased reporting rate, there is a large variation in the level of effort that each HFA staff member must exert to cover each province. While Malanje and Uíge have 14 and 16 municipalities, respectively, Lunda Sul and Zaire have only four and six municipalities, respectively. The number of municipalities and road conditions, especially during the rainy season that started in Q1, were a barrier to visiting all municipalities in each province. To solve this problem, HFA will reorganize the work of its staff allocated in the provinces and consider adding, on a call-in basis, an additional two DHIS2-IT staff members to support routine supervision work in Malanje and Uíge.

- **Need for free airtime to upload information into the DHIS2 platform:** Despite UNITEL providing a URL to have free access to the DHIS2 platform, in practice, the municipalities have needed to spend money to upload information into the cloud. During Q1, UNITEL and HFA have worked together in testing the platform to assure that no airtime consumed is paid for. Although it is reported to be fixed for most municipalities, it continues to be a work in progress and is expected to be solved in upcoming quarters.

5.5 Recommendations for next quarters

As previously reported, during FY19 HFA will focus on Improving Data Quality and Data Analyses for Decision Making within DHIS2. In this context, the most important recommendation is to work with the MoH in finding a mechanism within its own monitoring and supervision plan to improve the completeness and quality of data registration in HUs that is reported to the municipal level. HFA has already taken a preliminary step in that direction through the expansion of current routine supervision activities of the DHIS2-IT and Provincial MoH staff to review data registration in HUs. HFA hopes this step will trigger discussion amongst and actions taken by key players in the MoH, including HUs and municipal, provincial and central level entities.

The MoH already took an important step toward consolidating DHIS2 into the national health information system in suggesting provincial governors enforce registration on DHIS2, starting in Q2 FY19. HFA will take advantage of this interest to ensure efforts are also made to provide HUs with the means to improve data quality and reporting, e.g., having electricity and Internet access.

5.6 Proposed activities for Q2 FY19

According to the approved FY19 workplan, a series of activities have been planned for Q2 to improve data quality and analyses, with some key activities as follows:

- HFA and MoH staff will conduct routine supervision to municipal health offices, checking data entry into DHIS2 and solving problems with the platform. HFA and MoH staff will also visit key HUs to observe and improve data registration.
- Quarterly meetings will be conducted for data analysis and decision-making. These meetings will be led by the NMCP-HFA with municipal and provincial level staff to analyze data inconsistencies, interpret dashboards and make decisions. Within this activity, a one-time modality is suggested in Q2 to bring provincial-level participants to Luanda and conduct a two-to-three-day workshop with local staff.
- Monthly meetings should be hosted with the NMCP, GEPE and GTI to analyze the progress of DHIS2 and discuss problems and solutions.
- The DHIS2 platform should be evaluated to identify data weaknesses and ways to improve the platform.

Such activities are already included in the FY19 workplan and detailed in table 24 below:

table **24** Proposed Activities for Q2 FY19

ACTIVITY		Q2 FY19		
		Jan	Feb	Mar
DHIS-2: Data Quality and Data Analyses for Decision Making				
1	HFA and MoH staff to conduct joint, routine supervision of municipal health officers to assure data is entered in DHIS2 and platform problems solved, with supervision also conducted at key HUs to improve data registration.	X (6 provinces)	X (6 provinces)	X (6 provinces)
2	Quarterly meetings held, with one per province, bringing in all municipal staff for a training in data analysis and decision-making.		X (3 provinces)	X (3 provinces)
3	Monthly meetings with NMCP and GEPE/GTI to analyze malaria reporting rates, data analysis, and decision-making	X (Luanda)	X (Luanda)	X (Luanda)
4	Enter historical data after revising data formats and reviewing information available from previous periods.	X (6 provinces)	X (6 provinces)	X (6 provinces)
5	Assessment of DHIS2 Roadmap Implementation			X
Implementation of the health network quality improvement system (HNQIS) for malaria/ADECOS/FP				
6	Questionnaire (check-list) revision	X		
7	Configuration on tablets (check-list and HUs)		X	
8	Training supervisors on system use			X

table 24 cont | Proposed Activities for Q2 FY19

Southeast Asian Migrants Study				
9	PMI – CDC IRB approval of study design	X		
10	Fieldwork, pending CDC ethics committee's approval		X	X
Therapeutic Efficacy Study With Antimalarials TES Study)				
11	Training conducted, assuming the CDC and local ethics committee grant approval	X	X	
12	Fieldwork		X	X
Institutional Capacity Assessment of NMCP				
13	Conclusion of the NMCP process assessment	X	X	
14	Dissemination workshop			X
Costing of iCCM				
15	Conclusion of the NMCP process assessment	X		
16	Dissemination workshop		X	
ADECOS Monitoring				
17	Supervision visit to collect data from ADECOS	X		
18	Program a software to automatically extract data from KoBoCollect/ODK and link it to DHIS2	X	X	X
LLIN Use and Care Study				
19	Conduct training, pending local and JHU ethics committees' approval. PSI approval already received.approval). PSI approval already received.		X	
20	Fieldwork		X	X

5.7 Environmental Mitigation Monitoring plan

Health systems strengthening (HSS) activities under result 5 have a status of categorical exclusion and do not require reporting.

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

3.1 Background

HFA's 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 PSI, and is responsible for establishing a sustainable model for providing high-quality HIV/AIDS services.

3.2 Summary of Achievements in FY18

During the last year, HFA collaborated with INLS and GPSL to accomplish the following major achievements in the seven United States President's Emergency Plan for AIDS Relief (PEPFAR)-selected health facilities (HFs):

- The FY18 target of testing 43,845 people was achieved with 73,807 people tested, thus a target of 168% was met.
- Testing aimed to identify at least 5,843 HIV-positive individuals who did not know their status and thus were not on treatment, and 6,282 HIV-positive individuals were identified through testing. Thus, a target of 108% was met.
- At the end of FY18, 3,858 people were newly enrolled on antiretroviral therapy (ART), meaning 51% of the TX_NEW target for the period was met. However, after analyzing the target by HF, the curve of quantity of patients was continuously increasing since 2016, with two exceptions: Hospital Esperança (due to the change of its role to a School Hospital, therefore only treating complicated cases) and Hospital Pediátrico (due to children first being treated for other pathologies before initiating ART).
- At the end of FY18, 20,731 adults and children were receiving ART (the target was 22,003), indicating a 94% achievement of the TX_CURRENT target.
- The numbers of new tuberculosis (TB) cases identified during both halves of FY18 was 7,434. It was an achievement of 159% when compared with the annual target of 4,682. Additionally, the total number of HIV-positive individuals tested for TB was 6,649, an achievement of 169% when compared with the annual target of 4,005.
- The total number of HIV-positive patients diagnosed with TB was 879. This achievement is 117% when compared with the annual target of 750. However, only 472 TB patients initiated ART (70% of the target of 673), due to a lack of TB medicines available in HFs.
- For TB prevention, 3,510 HIV-positive individuals initiated isoniazid (INH) treatment (124% of the targeted 2,836), and 2,825 patients completed INH treatment (145% of the targeted 1,954). The total number of patients on ART

who were triaged for TB was 8,487, and 221 patients on ART initiated TB treatment. Thus, only 24% of the annual target of 918 patients was met, due to a lack of medicines at HFs.

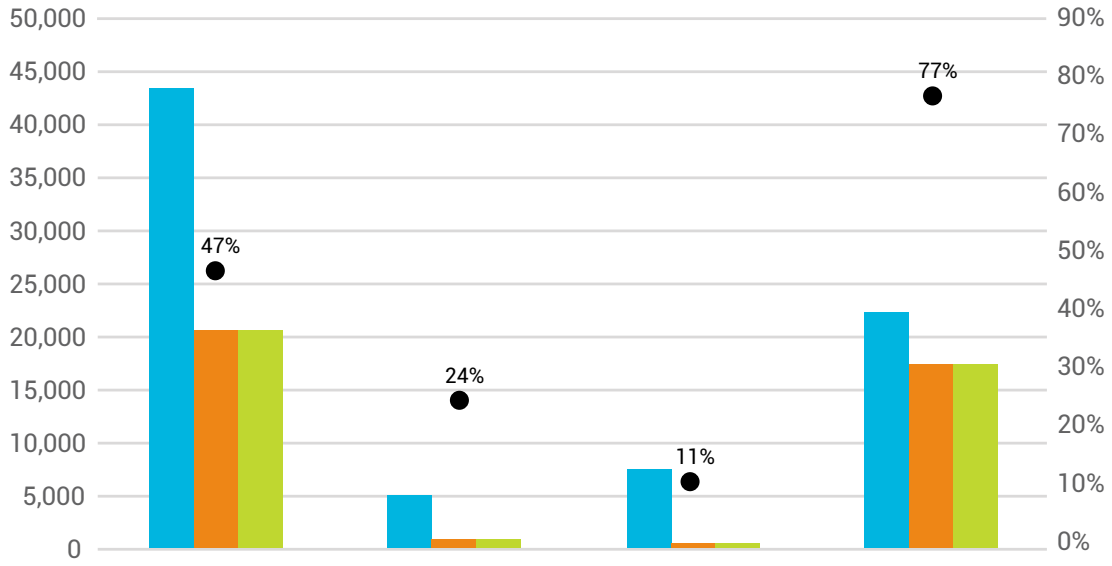
- During FY18, HFA continued to improve the index case testing and tracing (ICTT) strategy through the excellent work of community counselors and effective coordination with HF staff, including patient assistant facilitators (PAFs) and Case Managers (CMs) supported by the project. The high percentage of patients testing positive for HIV, with an average of 29%—regular testing in the HF is around 9%—and a high percentage of patients linked with treatment, with an average of 80%—normal linkage in the HF is around 50%—shows that ICTT is proving to be a high-yield strategy when compared with other testing modalities.

- For viral load suppression in the seven HFs (TX_PVLS), HFA tested 13,863 patients. Thus, 120% of the annual target of 11,513 was met. There were 10,068 test results for patients with VL<1,000 LDL (suppressed), thus meeting 109% of the annual target.

3.3 Targets and Achievements of Q1 FY19

During Q1 FY19, HFA implemented new tools and strategies to increase the number of patients who tested positive for HIV and were linked with ART, and improved adherence and retention on ART. The main results are discussed below:

figure **01** : Analysis of tested, positives, TX_NEW and TX_CURRENT for FY19 Q1

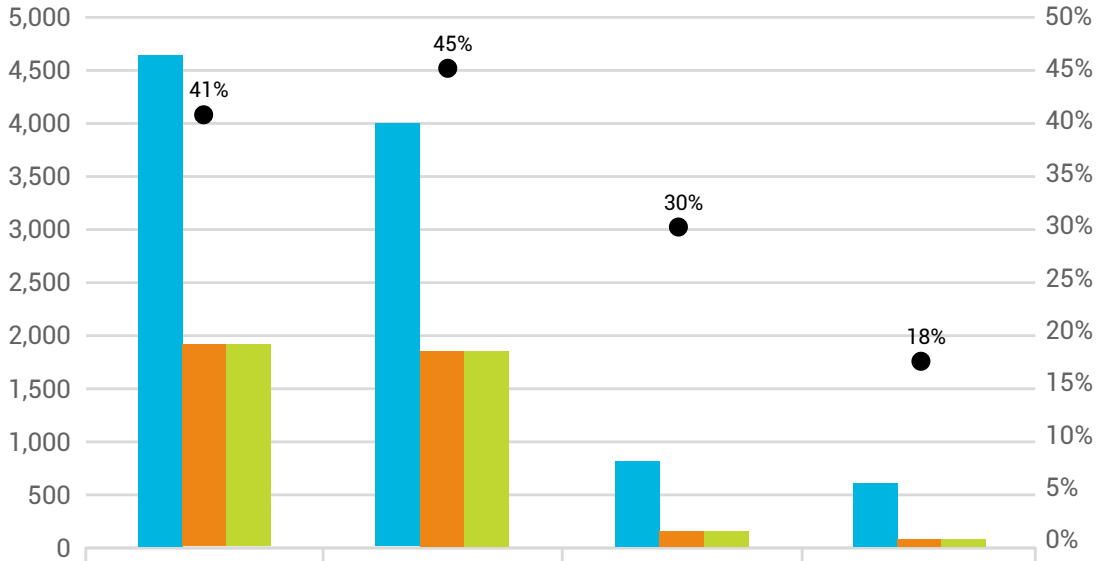


Source: Register Books and Clinic Process of HIV Services from the HFs-Elaboration: HF

The number of patients tested, then identified as HIV positive and TX_CURR during Q1 was greater than the annual target, assuming a 25% achievement per quarter. TX_NEW (828) is around 50% of the Q1 target (linkage rate = 51%), because there has not yet been enough time to see the results of interventions to address the causes identified for improving testing yield. Annexes 1, 2 and 3 show results on the evolution of tested, positives and TX_NEW by HF from Q1 FY18 to Q1 FY19. Almost all HFs increased their performance in at least one of the three indicators, with the exception of Hospital Esperança (due to it becoming a School Hospital and treating only complicated cases), and Hospital Pediátrico (due to the requirement that children be treated for other pathologies first, e.g., malnutrition, diarrhea, pneumonia and other infant infectious diseases, before initiating ART and being referred to another HF). Please see Annex 12 for TX_CURR by HF. See Annex 13 on following HIV-positive cases.

figure
02

HIV and TB testing and treatment for FY19 Q1



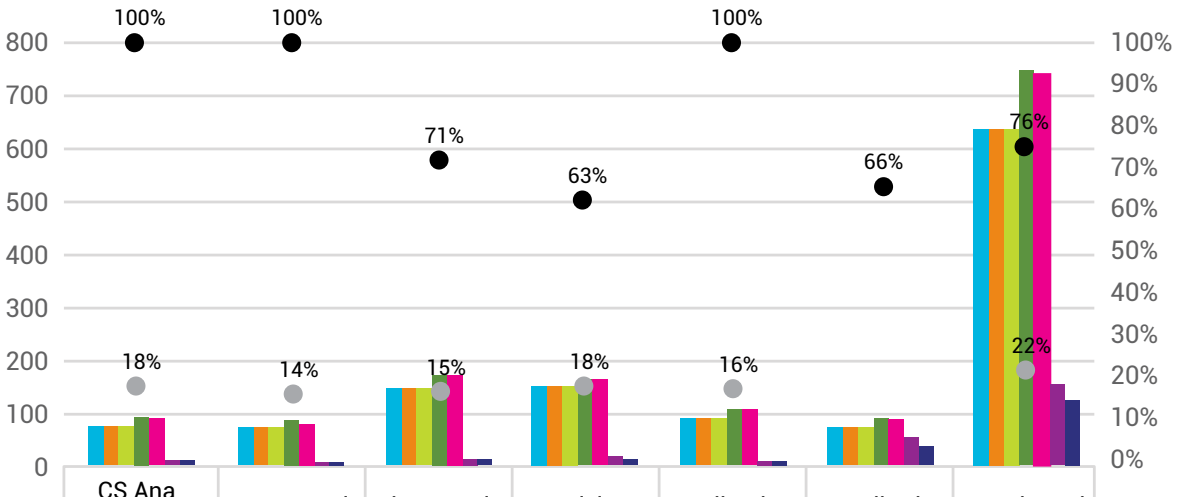
	TB_Stat (Denominator) TB New and Recurrent	TB_Stat (Numerator) TB with HIV Status	TB_Art (Denominator) TB HIV+	TB_Art (Numerator) TB HIV+ In Art
Annual Target	4,682	4,005	750	673
Q1	1,931	1,788	228	121
Annual	1,931	1,788	228	121
Target %	41%	45%	30%	18%

Source: Register Books and Clinic Process of HIV Services from the HFs-Elaboration: HF

During Q1 FY19, HFA identified 1,931 new and recurring patients with TB, which was 41% of the annual target. Of these patients, 1,788 knew their serological status (45% of the annual target), and 228 were HIV-positive (30% of the annual target). Of the 228 HIV-positive patients, 121 started ART (18% of the annual target). This target was not met because the remaining patients did not complete the two-week treatment required for TB Treat First, because TB medication was not available at HFs. See Annexes 4, 5, 6 and 7 for an analysis of TB_STAT and TB_ART by HF.

figure
03

Index cases, contacts, positives, linked and HTS_INDEX by health facility for FY19 Q1



	CS Ana Paula	CS Rangel	Dispensario	H DivinaH	KilambaH	PediatricoG	rand Total
Offered Index Case	82	78	148	156	95	79	638
Accepted Index Case	82	78	148	156	95	79	638
Realized Index Case	82	78	148	156	95	79	638
Identified Contacts	98	94	186	167	103	94	742
Tested Contacts	96	82	186	167	103	93	733
Positives	17	12	28	30	16	61	164
Linked	17	12	20	19	16	40	124
% Positives	18%	14%	15%	18%	16%	66%	22%
% Linked	100%	100%	71%	63%	100%	66%	76%

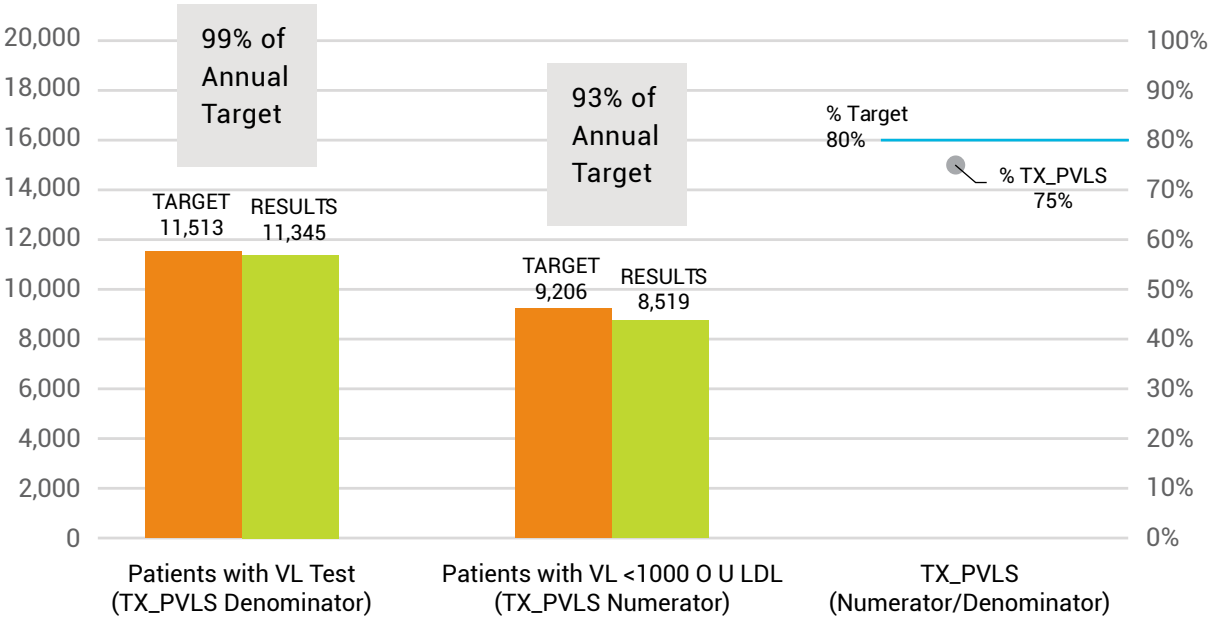
Source: Register Books and Clinic Process of HIV Services from the HFs-Elaboration: HF

Figure 3 above shows the high percent of positive cases found through the index case strategy (22%) and the high number of positive cases linked to ART (76%). This figure includes the new PEPFAR 2.3 indicator HTS_INDEX. Using tests offered, accepted and realized by index cases is a strategy that continues showing excellent and regular results (see Annex 8). See Annex 9 for a comparison between the positives found in the HFs versus index cases, and Annex 10 for index case comparisons by age group. Annex 11 shows positive contact cases. For contact cases of individuals who are younger than 15, 84% of their parents are positive and 35% of the adults' extramarital contacts are also positive.

The following Figure 4 shows the percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the laboratory information system within the past 12 months. Patients who had a VL test met 99% of the annual target, and 93% of these patients have a virally suppressed result (<1000 copies/ml). Annex 14 shows the percent of VL suppressed by HF. Almost all HFs are close to the annual target, with the exception of Hospital Pediátrico at 43% (annual target of 80%), due to the fact that a considerable number of its patients are orphans, and consequently they do not receive proper treatment.

figure
04

TX_PVLS for FY19 Q1



Source: Register Books of VL, SEGEP and Clinic process of HIV from the HFs-Elaboration: HFA

3.4 Constraints and Solutions

A major constraint is linking HIV-positive patients to ART and maintaining their adherence and retention to treatment. HFA is implementing many solutions to address this challenge, with some described below:

- PAFs conduct an active search for a patient on the same day that a patient misses his or her appointment and ensure that registration is initiated.
- In coordination with HIV focal points, PAFs conduct an active search to identify self-transfer patients and deaths and ensure that registration is initiated.
- HFA follows all positive cases using a recording tool designed for this purpose (see Annex 13). However, it will take some time to see the results of this effort, due to external factors and involved persons, e.g., churches, relatives, stigma, another pathology, etc., that can hamper starting ART.
- Improve the reference health system with "navigators," or activists who physically accompany HIV-positive patients to the reference HF to initiate ART.

Another major constraint is starting TB treatment late, which can delay the initiation of ART for co-infected patients (HIV/TB). To address this constraint, HFA is implementing the following solutions:

- Agreement with the National Program of TB Control (PNCT), PSM and HFA to improve the distribution of TB medication to HFs.
- Improve the One-stop Shop strategy, together with INLS, PNCT and HFA, and adapt it according to the needs of HFs in the country, paired with improving the active search and follow up of co-infected patients (TB/HIV).

3.5 Recommendations for next quarters

- Continue working with PNCT on all activities to improve the diagnose and treatment of TB/HIV co-infected patients.
- Reinforce the supervision of staff at HFs (case managers, PAFs, community counselors and data clerks) to improve the linkage of HIV-positive patients to ART, and consequently their adherence to and retention on treatment.
- Complete the integration of sexual and reproductive health (SRH) and family planning (FP) services with HIV/AIDS services at HFs, and in the community using integrated index case testing for HIV/SRH and TB.
- Strongly recommend including gender-based violence (GBV) as an activity in the integration of both services (HIV/SRH).

3.6 Proposed Activities for Q2 FY19

Result 3: Sustainable model for providing high-quality HIV/AIDS services established	Jan	Feb	Mar
1.Regular Activities			
1.1 Reinforce adherence training of technical staff in the seven HFs	X		
1.2 Create a micro plan on needs at the seven HFs and municipal health directories		X	
1.3 Implement integration of FP/SSR and HIV/AIDS services for activists		X	X
1.4 Implement integration of FP/SSR and HIV/AIDS services at the level of the seven HFs and communities		X	X
1.5 Implement integration of index case testing and tracing of HIV, GBV and TB			X
1.6 Implement management of viral load cascade with INLS technical staff			X
1.7 Reinforce the implementation of priority activities to improve the indicators of the number of screened patients for TB, the initiation of INH prevention and TB treatment	X	X	X
2.Training Activities			
2.1 Coordinate a basic training on GeneXpert results interpretation, working with INLS, PNCT, INIS and HFA		X	
2.2 Coordinate a training on counseling and testing in youths and adolescents, working with INLS, UNICEF and HFA	X		
2.3 Train M&E staff on the new PEPFAR 2.3 indicators and updates (e.g., age bands and sex disaggregation), conducted by the HFA M&E senior advisor	X		
2.4 Give refresher training on the screening and syndromic diagnosis of STIs in the seven HFs, relating to the INLS technical note from April 2018			X
2.5 Conduct training on the identification and management of therapeutic failure and management of the viral load cascade in the seven HFs			X

2.6 Conduct training on the key M&E indicators in the seven HFs, supported by HFA		X	X
2.7 Reinforce the adherence training for health technicians (nurses, medical doctors and psychologists)		X	
3. Supervision activities			
3.1 Conduct weekly supervision on the activities implemented in the seven HFs on the continuum of care (CoC) HFA senior advisors will conduct this supervision.	X	X	X
3.2 Conduct weekly supervision on the integrated FP/HIV services in the seven HFs. by the HFA FP responsible and HFA case managers will conduct this supervision.			X
3.3 Conduct monthly supervision on integrated ICTT in the community. The HFA FP and HIV senior staff responsible will conduct this supervision.			X
3.4 Conduct weekly supervision on counselling and testing, ICTT and adherence to ART. The HFA senior advisers and INLS technical staff will conduct this supervision.		X	X
3.5 Conduct weekly supervision on the CoC activities implemented in the seven HFs. HFA senior advisors will conduct this supervision.	X	X	X
3.6 Supervise TB cascade activities, including co-infection.		X	X
3.7 Supervise integrated activities in FP/HIV in the HFs and community.			X

3.7 Environmental Mitigation Monitoring plan

The HFA project trained 98 HF staff in environment compliance. This number is for the total staff who planned to be trained in the seven HFs during Q1. Trainings were conducted on the following topics:

table **25** Environmental compliance training topics

TRAINING		
Themes	Health Facility	Number of Staff who participated
Training in HIV activism for teens and young people	Pediatric Hospital	25
Training in retention and adherence to ART for lay people	7 HFs	26
Training in monitoring and evaluation	7 HFs	47
Total	7 Health Facilities	98

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

table 26 Supervision of staff providing HIV services

SUPERVISION		
Activity	Health Facility Involved	Staff involved in Supervision
Supervision/mentoring for nurses at HIV testing points	7 HFs	44
Supervision/mentoring for technicians (HIV focal points and clinicians) responsible for the care of co-infected patients (TB/HIV)	7 HFs	7
Supervision/mentoring for technicians (HIV focal points and clinicians) working in HIV services	7 HFs	7
Supervision of the active search conducted by PAFs of the patients who abandon treatment	7 HFs	16
Supervision of the ICTT strategy implemented by case managers and the coordinator responsible for these activities	6 HFs (Esperança has not implemented ICTT)	10
Supervision of the activities to strengthen the Kambas Group (adolescents and young people living with HIV and AIDS)	1 HFs	25
Supervision of the data analyst	7 HFs	09
TOTAL	7 HFs	118

table 27 Sustainable model for providing high-quality HIV and AIDS service for Q1 FY19

IR 3: Sustainable Model Providing High-Quality HIV/AIDS Services Q1 FY19				
Indicators	Achieved			
	Q1	Q2	Q3	Q4
1. Number of facility staff trained on biological waste management while working in the community	10	-	-	-
2. Number of facility staff trained by HFA on the use of standard operating procedures (SOPs) for HIV/AIDS services, including biological waste management	51	-	-	-
3. Number of trained staffs supervised by HFA on the use of SOPs for HIV/AIDS services	88	-	-	-

FAMILY PLANNING

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

4.1 Background

Since its inception, HFA has worked closely with stakeholders to strengthen the quality of FP services in Luanda and Huambo provinces. In this work, HFA has successfully supported DNSP to reactivate the Technical Working Group for Sexual and Reproductive Health (TWGSRH) and reprint strategies, training manuals and guidelines on SRH/FP.

In cooperation with the Provincial and Municipal Departments of Health in Luanda (GPSL) and Huambo (GPSH), 14 trainings were coordinated and more than 300 healthcare providers, both male and female, were trained on SRH/FP counseling and manual skills, including inserting and removing long-acting reversible contraceptives (LARCS), such as the intrauterine device (IUD) and implants. Gender integration was also included in the trainings.

4.2 Summary of achievements in FY18

During FY18, HFA implemented several advocacy activities on SRH/FP, trainings, supportive supervision and improvements in social and behavior change communication (SBCC). For advocacy, 17 women from a group of parliamentarians were trained in advocacy for SRH. This training gave skills to parliamentarian women to advocate for gender equity and equality, as well as reproductive health and rights. In coordination with the Provincial Health Directorate of Luanda (GPSL), an additional meeting was organized with municipal health directors and HFA implementors, namely PSI/Angola, MSH and Rede Mulher Angola (RMA) to present HFA's objectives and workplan. Municipal health directors showed great appreciation for the HFA project, and, according to them, it is important to strengthen health at the municipal level.

For trainings, 331 healthcare providers (282 female and 49 male from the public health sector) were trained in SRH/FP counseling and/or services in Luanda and Huambo. These providers offer SRH/FP services at all municipalities in Luanda and Huambo.

Concerning SBCC, 21 female and 9 male activists were trained in FP to provide group counseling on SRF/FP in HUs. The activists were assigned to 62 HUs. Throughout 2018, almost 53,000 women, men and adolescents were reached through communication activities in HUs in Luanda. HFA also started organizing the existing SRH strategy for SBCC, defined by the MoH.

To strengthen supportive supervision, USAID requested that HFA reduce the number of assisted HUs in Luanda and Huambo at the end of FY18. HUs were reduced from 108 to 22 in Luanda and 99 to 20 in Huambo. This change will allow the quality of services provided in selected units to be more closely monitored.

4.3 Targets and Achievements of Q1 FY19

In Q1, primary activities related to the following:

- Support one MoH delegate to participate in the 5th International Conference on Family Planning (ICFP) in Kigali, Rwanda.
- Organize activities related to the 16 Days of Activism against Gender-based Violence (GBV).
- Work with PSM to update the quantity of contraceptives for 2019.
- With Department for International Development (DFID) funding and through a United Nations Population Fund (UNFPA) procurement mechanism, PSI successfully advocated for the procurement of 130,000 injectable contraceptives (DMPA-SC, also known as Sayana Press) to be donated to the MoH for use in 42 HFA-supported facilities in Luanda and Huambo.
- Operationalization of the national SBCC strategy.

USAID Health for All RFA-654-16-000004														
Performance Monitoring Plan for Result 4														
Indicator Level	Performance Indicator	Baseline FY2018			FY19 target			Achieved Q1 FY19			Achieved Q1 / Target FY19			
								N=22	N=20	N=42	N=22	N=20	N=42	
		N=22	N=20	N=42	N=22	N=20	N=42	Luanda	Huambo	Total	Luanda	Huambo	Total	
		Luanda	Huambo	Total	Luanda	Huambo	Total	Q1	Q1		Q1	Q1		
Activity														
A4.1	**Percentage of USG-assisted service delivery points (SDPs) offering FP/RH counseling or services**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	
	Numerator	22	20	42	22	20	42	22	20	42				
	Denominator	22	20	42	22	20	42	22	20	42				
A4.2	**Percentage of USG-assisted service delivery points that experienced a stock out, at any time during the reporting period, of a contraceptive method that the SDP is expected to provide**	**95.5%**	**100%**	**97.6%**	**86.4%**	**90%**	**88.1%**	**86.4%**	**75%**	**81%**	**100%**	**120%**	**91.9%**	
	Numerator	21	20	41	19	18	37	19	15	34				

A4.2	Denominator	22	20	42	22	20	42	22	20	42			
	Female condom	**86.4%**	**100%**	**92.9%**	**77.3%**	**90%**	**83.3%**	**86.4%**	**70%**	**78.6%**	**89.5%**	**128.6%**	**94.3%**
	Numerator	19	20	39	17	18	35	19	14	33			
	Denominator	22	20	42	22	20	42	22	20	42			
	Male condom	**45.5%**	**50%**	**47.6%**	**36.4%**	**40%**	**38.1%**	**27.3%**	**50%**	**38.1%**	**133.3%**	**80%**	**100%**
	Numerator	10	10	20	8	8	16	6	10	16			
	Denominator	22	20	42	22	20	42	22	20	42			
	IUD	**36.4%**	**85%**	**59.5%**	**27.3%**	**75%**	**50%**	**18.2%**	**55%**	**35.7%**	**150%**	**136.4%**	**71.4%**
	Numerator	8	17	25	6	15	21	4	11	15			
	Denominator	22	20	42	22	20	42	22	20	42			
	Implant	**31.8%**	**100%**	**64.3%**	**22.7%**	**90%**	**54.8%**	**31.8%**	**65%**	**47.6%**	**71.4%**	**138.5%**	**87%**
	Numerator	7	20	27	5	18	23	7	13	20			
	Denominator	22	20	42	22	20	42	22	20	42			
	Injectable	**31.8%**	**85%**	**57.1%**	**22.7%**	**75%**	**47.6%**	**18.2%**	**50%**	**33.3%**	**125%**	**150%**	**70%**
	Numerator	7	17	24	5	15	20	4	10	14			
	Denominator	22	20	42	22	20	42	22	20	42			
	Oral Contraceptive Pill	**9.1%**	**15%**	**11.9%**	**4.5%**	**10%**	**7.1%**	**4.5%**	**5%**	**4.8%**	**100%**	**200%**	**66.7%**
	Numerator	2	3	5	1	2	3	1	1	2			
	Denominator	22	20	42	22	20	42	22	20	42			

	Emergency Contraceptive Pill	**77.3%**	**15%**	**47.6%**	**68.2%**	**10%**	**40.5%**	**50%**	**75%**	**61.9%**	**136.4%**	**13.3%**	**152.9%**
A4.2	Numerator	17	3	20	15	2	17	11	15	26			
	Denominator	22	20	42	22	20	42	22	20	42			
A4.3	**Couple year protection in USG-supported programs**	**17,600**	**8,000**	**25,600**	**18,480**	**8,400**	**26,880**	**17,749**	**423**	**18,172**	**96%**	**5%**	**67.6%**
A4.4	Percent of health facilities whose providers reported a quality of care score >= 80% for the management of FP services (+)	40.9%	40%	40.5%	40.9%	40%	40.5%	0%	0%	0%	0%	0%	0%
	Numerator	18	16	34	18	16	34	0	0	0			
	Denominator	44	40	84	44	40	84	44	40	84			
A4.5	Number of health care workers who successfully completed an in-service training program	168	112	280	200	100	300	0	0		0%	0%	0%
A4.6	Number of protocols finalized and approved	4[6]		4	3	3	0	0	0%	0%			
A4.7	Number of people trained with USG funds	250	150	400	250	150	400	30	0	30	12%	0%	7.5%
A4.8	Number of USG-assisted community health workers (CHWs), or activists, providing FP information, referrals and/or services during the year	30[4]	N/A	30	44	40	84	30	0	30	68.2%	0%	35.7%

[4]The strategies are national; therefore, they cannot be estimated by provinces.

[6]In FY18, SBCC activities were only conducted in Luanda. SBCC activities will be expanded to Huambo in FY19.

Strengthen advocacy with the MoH and partners

- **5th International Conference on Family Planning (ICFP)**

In terms of advocacy, HFA supported the participation of MoH delegates to the 5th International Conference on Family Planning (ICFP 2018) held in Kigali, Rwanda. PSI/Angola, in cooperation with UNFPA and PSM, advocated for the participation of Angolan delegates to the conference, which took place from Nov. 12-15, 2018. The conference's theme was "Investing for a Lifetime of Returns." Angola was represented by 10 people from the MoH, along with other representatives from local and international organizations based in Angola. The MoH representatives included Dr Silvia Lutukuta (Minister of Health), Dr Helga Freitas (Minister's Assistant), and Lizandra Cristóvão (Consultant of the Secretariat of the State for Hospital area), who attended the conference at the invitation of the Ministry of Rwanda. The table below shows the list of conference representatives.

table **28** Representatives at the 5th International Conference on Family Planning

#	Organization	Name	Role
1	MOH - DNSP	Dr. Henda A. de Vasconcelos	Head of the SRH Department
2	MOH – DNSP	Dr. Mansitambi João Luz	Family Planning Coordinator
3	MOH – DNSP	Dr. Silvia Amaral	Medical Doctor
4	UNFPA*	Dr. Florbela Fernandes	Angola Country Representative
5	AGOA*- Angola OBGYN Association	Dr. Pedro de Almeida	Professor at Faculty of Medicine
6	AGOA*- Angola OBGYN Association	Dr. Mário Bundo	President of the AGOA
7	PSI	Eva Fidel	Program Manager-Family Planning
8	PSI*	Pedro Zola	Director of Strategic Development
9	PSI*	Suse Emiliano	Marketing Director
10	PSM	Jane Sousa	Technical Adviser for Reproductive Health

*These participants were not funded by USAID, but by other sources.

During the conference, all Angolan delegates were invited by the Rwandan Minister of Health to visit three HUs in Kigali. The visits' objective was to understand the Rwandan health system and service delivery. Participation in the conference was a unique opportunity for the Angolan delegation to learn about positive experiences in SRH/FP from other countries. For example, at the end of the field visit, the Angolan Minister of Health shared that she was impressed by how countries, like Rwanda, were able to improve health services with little financial support.

- **FP2020 Meeting**

During the conference, UNFPA coordinated a pre-meeting between FP2020 committee members and PSI/Angola and PSM to understand Angola's current FP situation and prepare the meeting with the Angolan Minister of Health. During the pre-meeting, the efforts UNFPA, PSI and PSM are implementing to advocate for the FP2020 in Angola were mentioned. For instance, an explanatory booklet on FP2020 in Portuguese was developed and given to the MoH. After the meeting, the FP2020 committee met with the Angolan Minister of Health to discuss the possible inclusion of Angola in the FP2020 initiative. The Minister showed some interest and mentioned that more internal discussion was needed. As a result, a meeting was later led by Dr. Helga Freitas, assistant to the MoH, to discuss the implications of pledging onto the FP2020 initiative with DNSP and partners.

- **Re-introduction of Sayana Press in Angola**

Given PSI's experience in international partnerships, PSI/Angola has advocated with DFID to fund the donation of Sayana Press (DMPA_SC - hormonal contraceptive injectable for three months) for the Angolan MoH. The product was procured through a UNFPA mechanism.

This effort, which has required coordinated action between PSI/Angola and UNFPA, offers the country a number of advantages:

- Acquisition of the injectable contraceptive Sayana Press at no cost to the country.
- Refresher knowledge for healthcare providers in handling this contraceptive in the Luanda, Huambo and Huila provinces (implementation provinces - first phase).
- Reduced costs in the purchase of expendable materials, namely, syringes, as Sayana Press already contains a syringe.
- Increased contraceptive choice among women.
- Prevention of unwanted pregnancies in approximately 32,000 women in 2019.
- Quality control and follow-up customer service.
- In the long term, the possibility of extending contraceptive use at the national level in accordance with the norms and guidelines of the MoH.

In early January, a donation of 130,000 injectables arrived in Angola, which are currently stored at CECOMA (Central Purchasing of Medicines and Medical Supplies of Angola). With the support of PSI/Angola, UNFPA and partners, DNSP is preparing a refresher training on using these injectables.

16 Days of Activism Against Gender-based Violence (GBV)

To mark the 16 Days of Activism Against GBV, Rede Mulher Angola (RMA), in coordination with the Ministry of Social Action, Women and Family (MASFAMU) and partners, prepared several activities and linked them with the local slogan:

"My body, every day and everywhere! Safety and Respect for Girls and Women." Key activities included:

- Radio debate: A radio debate about the consequences of GBV was held on Nov. 20, 2018. Two GBV survivors shared their testimonies, then answered questions from the radio hosts and listeners.

- Public session: A public session was held on Nov. 28-29, 2018, with four topics discussed: 1) violence; 2) a closer look at violence; 3) responding to GBV in service delivery, a security system and protections for sex workers; and 4) sexuality and human rights. This activity showcased 12 speakers, with more than 100 participants from civil society organizations.

- Roundtable meeting: A roundtable meeting on Sexual and Reproductive Health and Gender was held on Dec. 12, 2018. The meeting was implemented in coordination with MASFAMU and the Forum of Women Journalists. The meeting's main objective was to allow a space for health professionals, civil society members, parliamentarians and youth to openly discuss the social context of SRH and gender in Luanda. Dr Luisa Damiao, President of the Women Parliamentarian Group, was one of the 64 participants, and she assured that the group will increase its support for women's health.

Quantification of Contraceptives

PSI/Angola worked with GHSC-PSM to update the national reproductive health commodities quantification (2017-2021). Quantified products included contraceptives, such as pills (both combined oral contraceptives and the progesterone-only pill), condoms (female and male), injectables, IUDs and implants. The updated forecast, which covers 2019, aims to support the MoH to have a realistic estimate of the current need for contraceptives. Compared to the previous forecast, the updated version is based on the number of women of reproductive age, including possible new users of contraceptives. Additionally, changes were made to the estimates of IUDs, implants, injectables and male condoms.

The updated quantification presents three scenarios:

- The first scenario represents a forecast based on the number of current users of each contraceptive method.

- The second scenario uses a method mix that considers there will be an increase in IUD and implant users.

- The third scenario also proposes a method mix, but considers an increase in injectable users.

The updated version was submitted to DNSP for approval.

Improved supportive supervision

During FY17 and FY18, HFA supported a total of 207 HUs with SRH/FP. Among these HUs, 108 were located in Luanda and 99 in Huambo province. USAID requested that HFA select about 25% of the initial HUs to benefit from a more focused intervention package, which includes in-depth supervision, training in FP, youth-friendly services and gender integration. As a result, 22 priority HUs were selected in Luanda and 20 in Huambo to benefit from this package. The selected HUs will have an assigned quality control supervisor to ensure compliance with quality standards. The remaining HUs will continue benefiting from general FP trainings. This new strategy will help HFA strengthen health services in the selected HUs, which can then become role models for other HUs.

Selected HF in Luanda		
#	Municipality	Health Facility
1	Belas	CS do Kilamba
2	Belas	CS Ramiros
3	Cacuaco	Hosp. M. Cacuaco
4	Cacuaco	CS Sequele
5	Cazenga	CS Vila da Mata
6	Cazenga	Hosp. Cajueiros
7	Icolo Bengo	Hosp. Icolo Bengo
8	Kilamba Kiaxi	Hosp. Especializado Kilamba Kiaxi
9	Kilamba Kiaxi	CS Palanca II
10	Kissama	CS Cabo Ledo
11	Luanda	CS Cassequel
12	Luanda	Maternidade Lucrecia Paim
13	Luanda	CS Bairro Operário
14	Luanda	CS Samba
15	Luanda	CS Rangel
16	Luanda	CS 4 de Fevereiro
17	Talatona	CS Chimbicado
18	Talatona	CS Mbondo Chapeu
19	Talatona	CS Benfica
20	Viana	Hosp. Mãe Jacinta
21	Viana	CS Viana I
22	Viana	CS Viana II

Selected health facilities in Huambo		
#	Municipality	Health Facility
1	Bailundo	Centro Materno Infantil do Bailundo
2	Bailundo	Centro de Saúde do Luvemba
3	Ecunha	Centro Materno Infantil da Ecunha
4	Ecunha	Posto de Saúde do Caliamama
5	Huambo	Hospital Central do Huambo - sala do Planeamento Familiar
6	Huambo	Centro Materno Infantil da Mineira
7	Huambo	Hospital do Cambiote – sala de Planeamento Familiar
8	Huambo	Repartição Municipal do Huambo - sala de Planeamento Familiar
9	Caála	Centro Materno Infantil da Caála
10	Caála	Posto de Saúde da Calenga
11	Catchiungo	Centro Materno Infantil do Catchiungo
12	Londuimbali	Centro Materno Infantil do Londuimbale
13	Londuimbali	Centro Materno Infantil do Alto Hama
14	Longonjo	Centro Materno Infantil do Longonjo
15	Chicala-Tcholohanga	Centro Materno Infantil da Chicala Cholohanga
16	Chcala-Tcholohanga	Posto de Saúde de Candumbo
17	Mungo	Centro Materno Infantil do Mungo
18	Mungo	Posto de Saúde da Ngadalinha
19	Tchinjenje	Centro Materno Infantil do Tchinjenje
20	Ucuma	Centro Materno Infantil do Ucuma

For supportive supervision, 22 HUs were visited in Luanda and 20 in Huambo. In Luanda, HUs were visited two or three times per month. The number of visits varied according to healthcare providers' skills. For instance, the newly trained healthcare providers have a greater need for supportive supervision than the more experienced healthcare providers. Recently trained healthcare providers also require more assistance to deliver LARCs, such as IUDs and implants. As a positive, all HUs in Luanda had all contraceptive methods available during Q1. However, HUs were in great need of expendable materials, medical supplies and equipment, such as gynecological beds.

In Huambo, HUs received one or two visits . Most HUs needed IUDs, implants and injectables. Additionally, there was a great need for supplies, expendable materials, equipment and reporting forms. To mitigate challenges in HFs, HFA is working with provincial health departments in both Luanda and Huambo to improve conditions.

Social and behavior change communication

- Operationalization of the National Communication Strategy for Ideal Moment and Healthy Spacing of Pregnancy/ Family Planning - MIESG/PF Strategy

To lead the operationalization of the existing National Communication Strategy, RMA hired a local consultant who has worked in qualitative research in Angola for 10 years, Susana Mendes. The National Communication Strategy particularly targets adolescents.

Based on an analysis of prior programs in other countries—namely Adolescents 360 in Ethiopia, Tanzania and Nigeria and the Ignite project in Mozambique—the need for more information regarding Angolan adolescents was evident. There is currently no in-depth knowledge about who adolescents really are, other than demographic indicators available from the census and the Luanda Technical Health School (IMS). Understanding the particularities of this singular group is key to designing transformative interventions. The activities plan and the keystone design framework used to guide the process were discussed with the Reproductive Health and Health Promotion Departments on Dec. 6, 2018. Both departments showed a commitment in their willingness to participate, and actual participation in and contributions to the design phase. The main goals of this qualitative research are defined as follows:

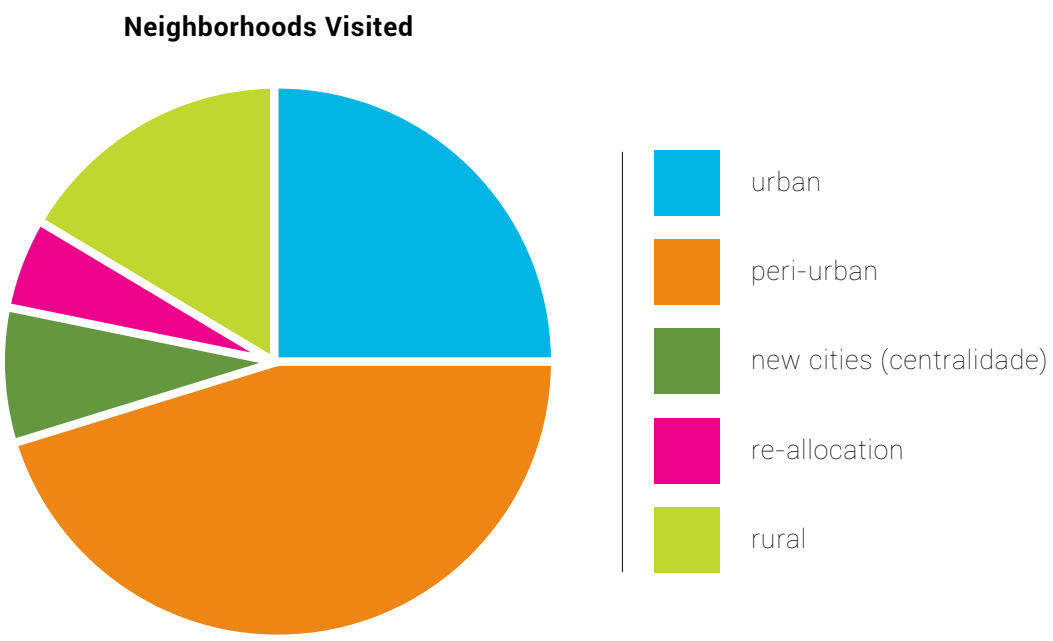
- Obtain an in-depth understanding of Angolan teenagers aged 15-19.
- Identify and group adolescent-type profiles (needs, preferences, characteristics, etc.).
- Assess adolescents' perceptions about health and well-being, knowledge, attitudes and practices for positive SRH.
- Understand contextual needs, constraints and opportunities to access SRH services and counseling.
- Produce specific insights for the operationalization of a communication strategy for adolescents in Angola.
- Create an innovative communication campaign involving the target group at all stages of development.

The first step was to recruit and train a team to do data collection, recognizing that there are specific communication skills needed for qualitative data collection. To train the team, a technical workshop was held at Hotel Veneza from Dec. 12-13, 2018. A national consultant led the workshop, and RMA's communications coordinator co-facilitated. A total of 18 people participated, including four representatives from the SRH and Health Promotion (HP) Departments of DNSP.

The team was trained and fieldwork started in 28 places where adolescents usually are observed and analyzed. The places were categorized by 22 urban and peri-urban areas and, per the SRH and HP departments' suggestions, six rural areas. The areas in Luanda province are divided keeping in mind a representative ideal and the adolescent profile of Angola. The distribution is illustrated in the figure below:

figure
05

Neighborhoods visited during fieldwork



Talatona	1
Golf II	1
Morro Bento II	1
Morro Bento I	1
Kilamba	2
Camama	2
Viana-centro	2
Viana-Estalagem	2
Zango III	2
Sequele	3
Cacuaco-Vidrul	2
Nova urbanizacao	1
Cacuaco-Vila	2
Sambizanga	5

Cazenga	2
Cassequel	1
Calemba	1
Rocha Pinto	2
Samba	2
Ilha	4
Malanga	4
Benfica	2
Funda	1
Calumbo	1
Mb. Calumbo	2
Catete	2
Bom Jesus	2
Muxima	2

- 56 group interviews (two to five participants) were conducted with adolescents aged 15-19 with different profiles, socio-economical levels and school attendance diversity.
- Three groups did not allow interviews to be recorded, but all available interviews will be fully transcribed for content analysis.
- The interviewers always went in the field in pairs of one woman and one man. This structure has two main reasons: 1) security in some riskier areas and 2) gender inclusivity in terms of bringing both adolescent girls and boys into the conversation from the initial communication design phase.

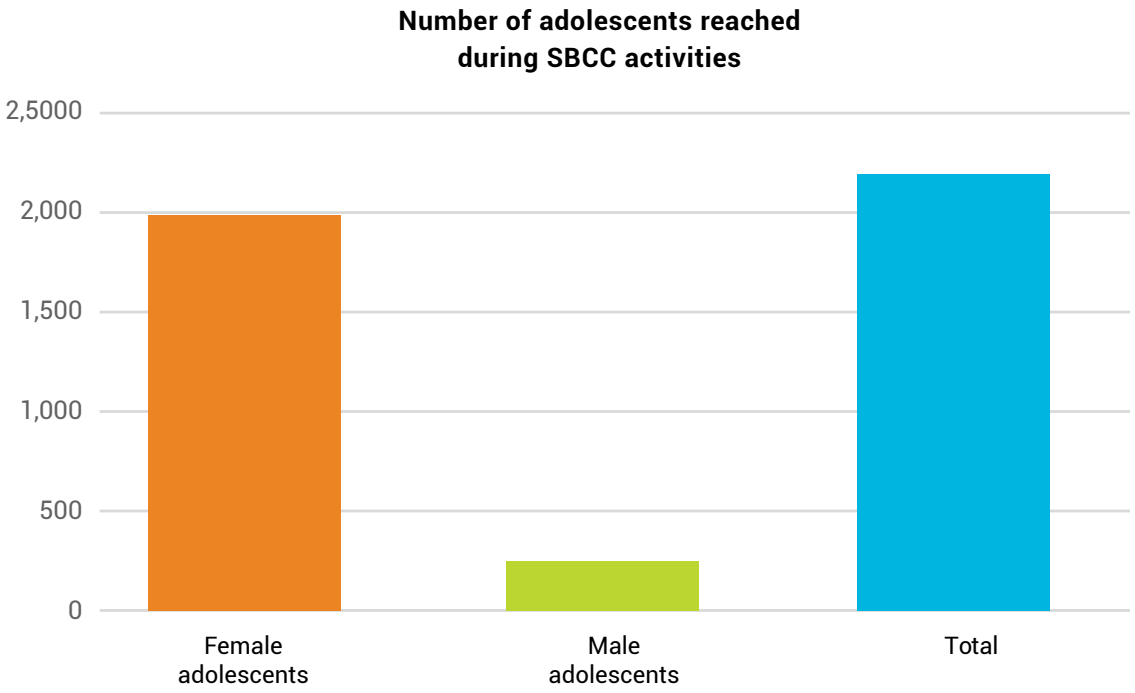
- Preliminary information from this initial phase will inform the second phase of fieldwork to take place in January 2019.

- Throughout all stages, technical guidance was provided to the RMA team by a Senior Communications Advisor from PSI headquarters, Mathias Pollock, and the PSI Angola Marketing and Communications Director, Suse Emiliano.

Social and behavior change communication activities in the health units

During the first quarter, the SBCC activities were targeted toward adolescents and youth due to the MoH's strategic approach of promoting safer sexual and reproductive behavior among this age group. Therefore, activists were actively reaching adolescents and youth in HUs and promoting education on SRH, as well as the advantages and side effects of contraceptives. During Q1, about 2,247 adolescents and youth from 14-24 years of age were reached. Among them, 2,023 were female clients and 224 were male clients in the HUs. The figure below shows the disparities between female and male adolescents reached during SBCC activities:

figure **06** Adolescents reached during SBCC activities



4.4 Constraints and Solutions

Primary constraints faced during implementation are described as follows:

- Lack of coordination between GPSL and HFA activities. GPSL does not have an annual workplan. Usually monthly plans are made, but the plans are shared with some delays. The proposed solution was to involve HFA in GPSL monthly planning.

- The SBCC planning used during Q1 was generating demand mostly for women, but not youth. To overcome this situation, an improved SBCC strategy is being developed to better reach adolescents and youth.

4.5 Recommendations for next quarters

The project has several key recommendations for the next quarter:

- Support the GPSL Department of SRH/FP to develop an annual workplan. Having an annual workplan will help the GPSL set priorities and better coordinate its work with partners to increase performance results with few resources. For example, if properly coordinated, HFA and GPSL can schedule monthly joint supervisions throughout FY19 using HFA transportation.
- Reactivate the youth-friendly health services in selected HUs in Luanda and Huambo to increase demand and provide appropriate services for adolescents and youth.

4.6 Proposed activities for Q2 FY19

Proposed actions for the next quarter include the following:

- Disseminate existing policies, such as the National Family Planning Strategy 2017-2021, the National Communication Strategy, the Manual of Orientation Against Domestic Violence and the Family Planning Training Manual.
- Support DNSP and the Department of Provincial Health in Luanda and in Huambo (GPS) to build a RH/FP workplan for FY19.
- Hold monthly technical working group meetings.
- Conduct advocacy for media integration by training journalists and TV hosts how to report on gender and FP.
- Lead a DHIS2 training with Municipal Family Planning focal points in Luanda and Huambo.
- Integrate youth-friendly health services in the 44 selected HUs in Luanda and Huambo.
- Integrate HIV and FP services in the selected HUs in Luanda and Huambo.

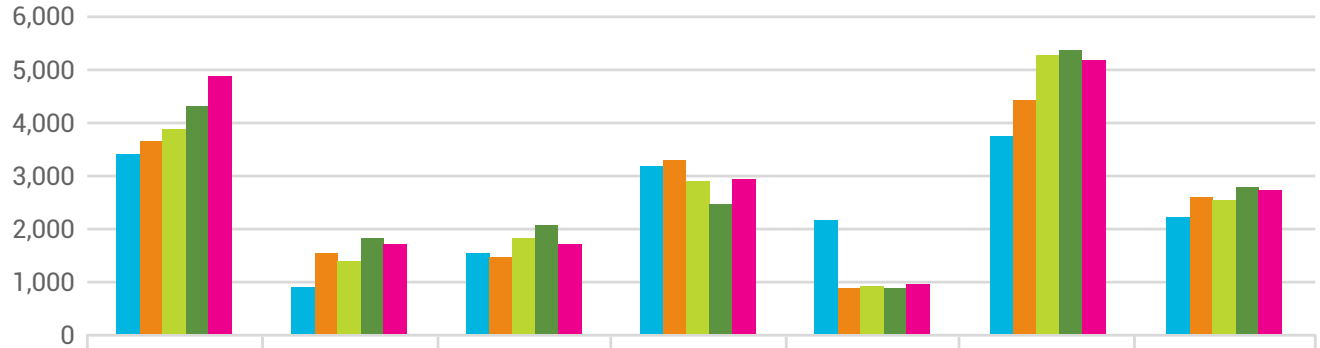
4.7 Environmental Mitigation and Monitoring plan:

Activities under R4 have a status of categorical exclusion and do not require reporting.

Annexes

annex
01

Tested Evolution by Health Facility

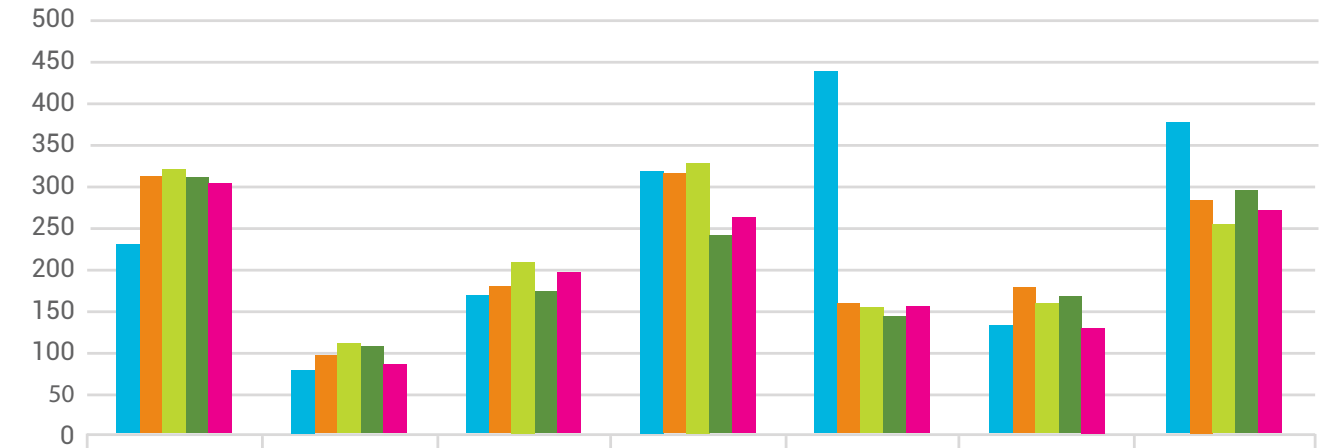


	CS Ana Paula	CS Rangel	Dispensário	H Divina	H EsperanÇa	H Kilamba	H Pediatrico
FY18 Q1	3,393	932	1,510	3,107	2,167	3,798	2,389
FY18 Q2	3,675	1,506	1,431	3,228	900	4,423	2,569
FY18 Q3	3,953	1,423	1,889	2,946	954	5,341	2,500
FY18 Q4	4,234	1,844	2,093	2,451	902	5,393	2,856
FY19 Q1	4,965	1,715	1,699	2,981	985	5,299	2,781

Source: Register Books and Clinic Process of HIV Services from the HFs-Elaboration: HFA

annex
02

Positive Test Evolution by Health Facility

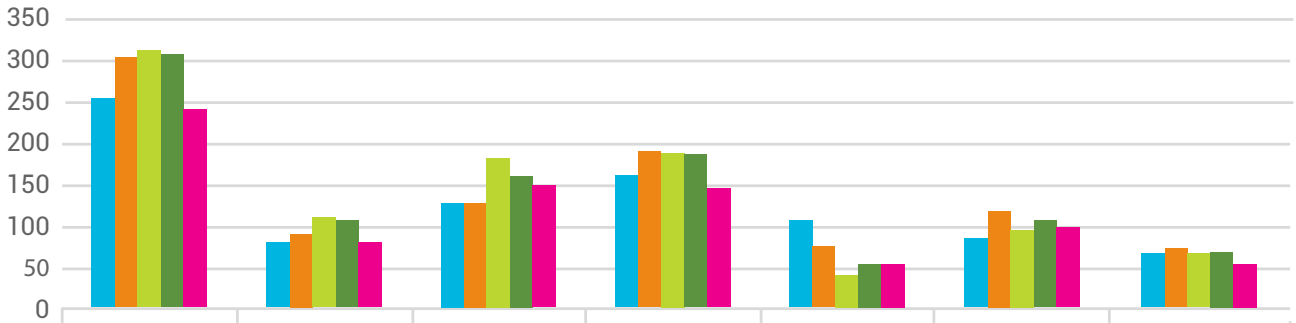


	CS Ana Paula	CS Rangel	Dispensário	H Divina	H EsperanÇa	H Kilamba	H Pediatrico
FY18 Q1	236	71	170	327	443	138	376
FY18 Q2	314	95	183	321	166	171	279
FY18 Q3	326	118	212	335	158	154	255
FY18 Q4	312	104	177	245	142	161	293
FY19 Q1	306	82	194	260	160	134	264

Source: Register Books and Clinic Process of HIV Services from the HFs-Elaboration: HFA

annex
03

TX_New Evolution by Health Facility

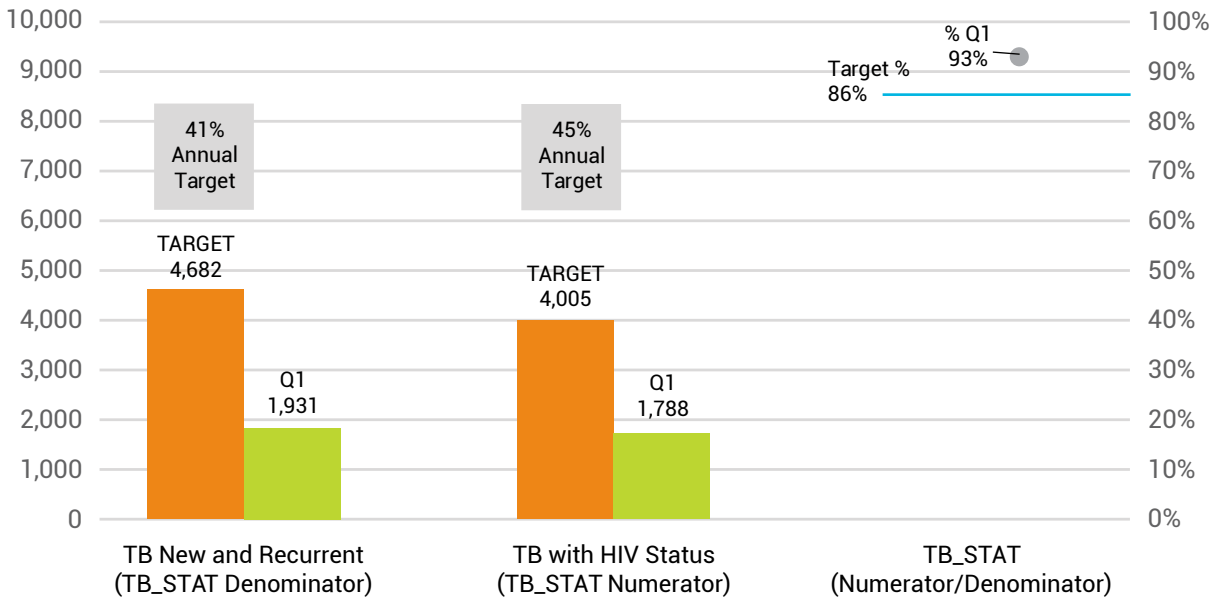


	CS Ana Paula	CS Rangel	Dispensário	H Divina	H EsperanÇa	H Kilamba	H Pediatrico
FY18 Q1	254	75	134	161	112	89	68
FY18 Q2	304	84	134	187	76	120	77
FY18 Q3	315	112	172	184	44	95	68
FY18 Q4	307	111	161	183	52	112	67
FY19 Q1	243	74	150	148	52	100	61

Source: Register Books and Clinic Process of HIV Services from the HFs-Elaboration: HFA

annex
04

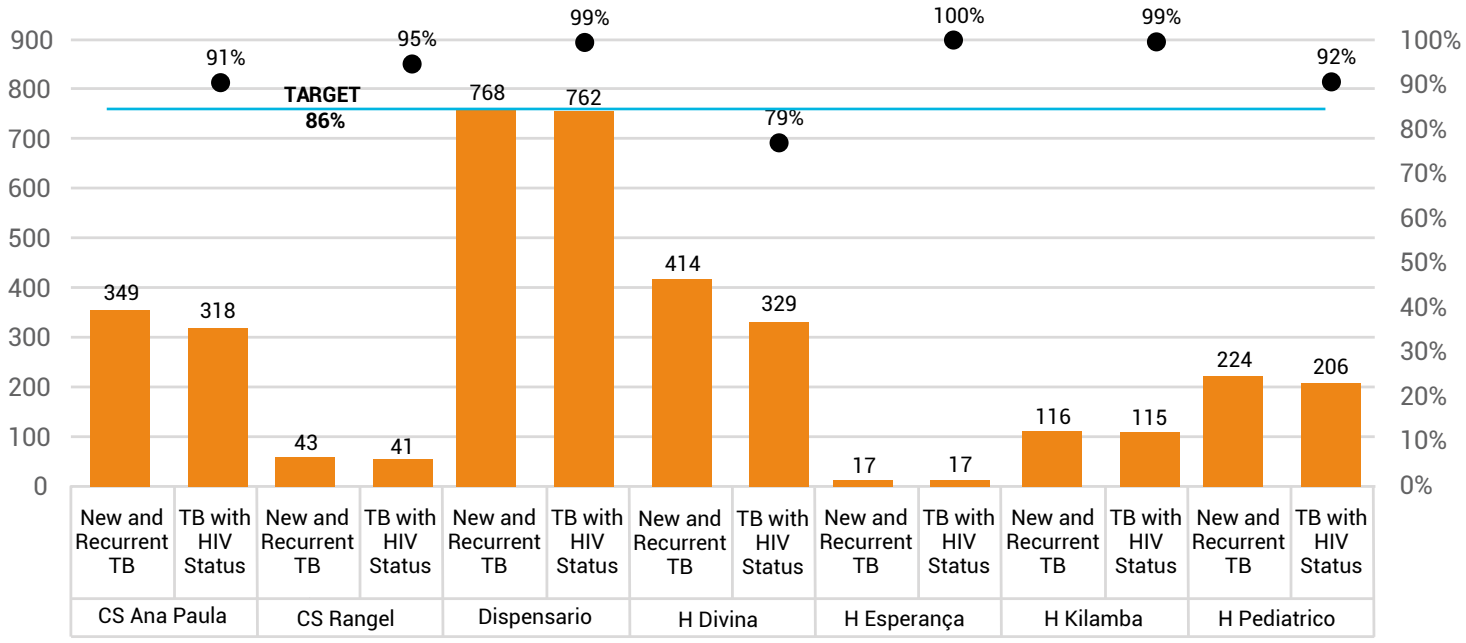
TB_STAT



Source: Register Books and Clinic Process of HIV Services from the HFs-Elaboration: HFA

annex
05

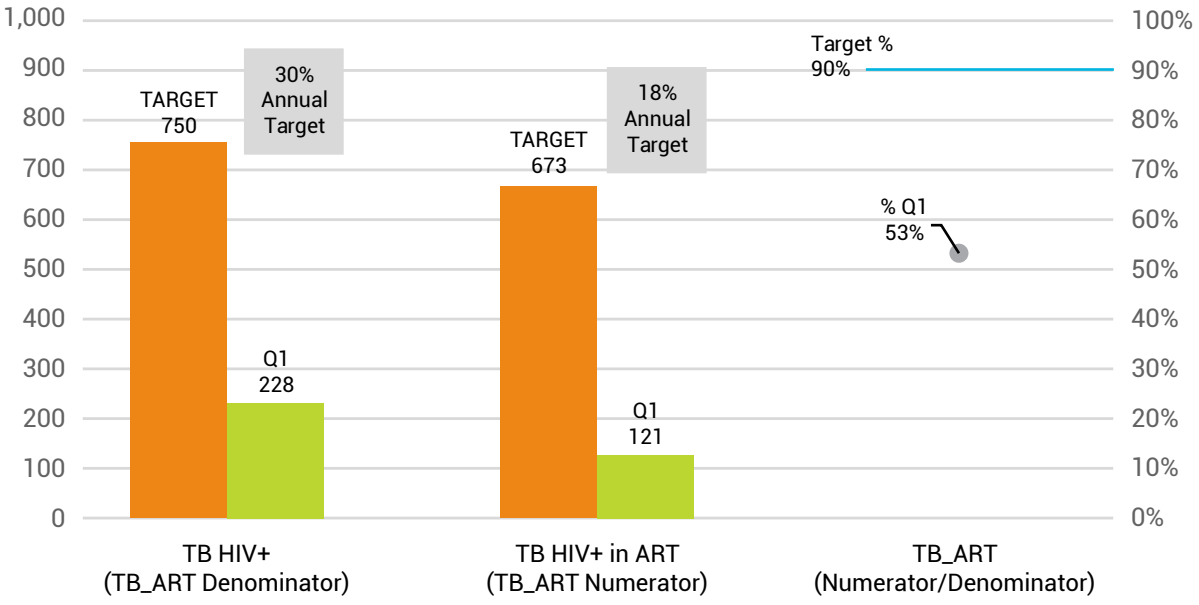
TB_STAT by Health Facility



Source: Register Books and Clinic Process of HIV Services from the HFs-Elaboration: HFA

annex
06

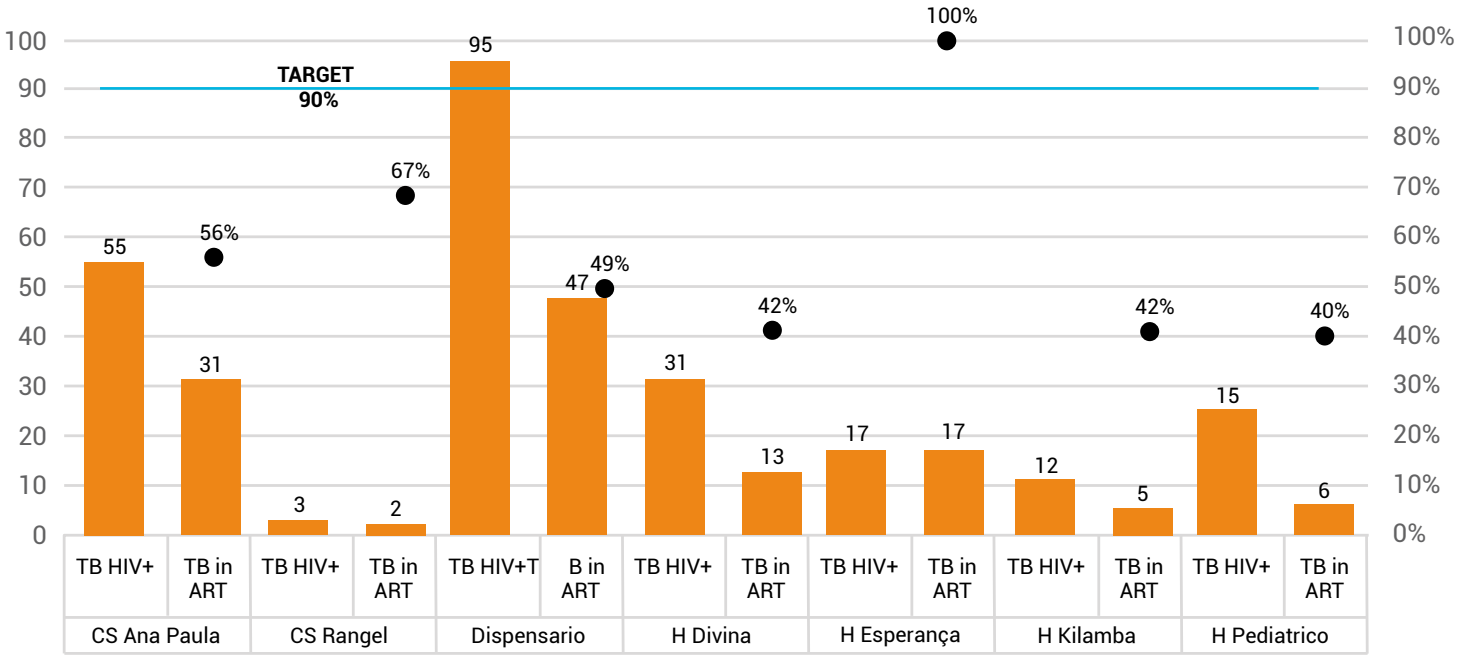
TB_ART



Source: TB Register Books, TB Record Treat, SEGEP, Clinic Process of HIV from the HFs. - Elaboration: HFA

annex
07

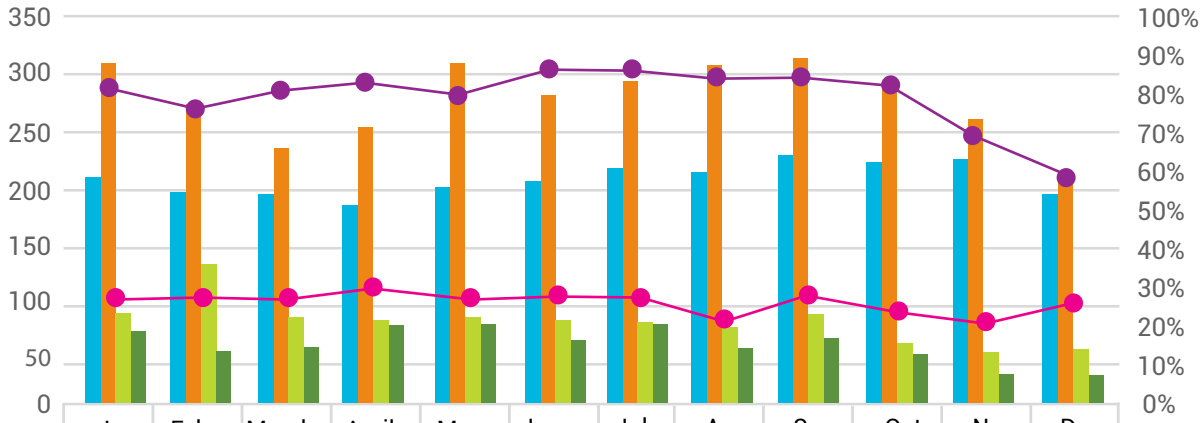
TB_ART by Health Facility



Source: TB Register Books, TB Record Treat, SEGEP, Clinic Process of HIV from the HFs. - Elaboration: HFA

annex
08

FY2019-Q1 Index Cases, Contacts, Positives, and Linked from January to December 2018

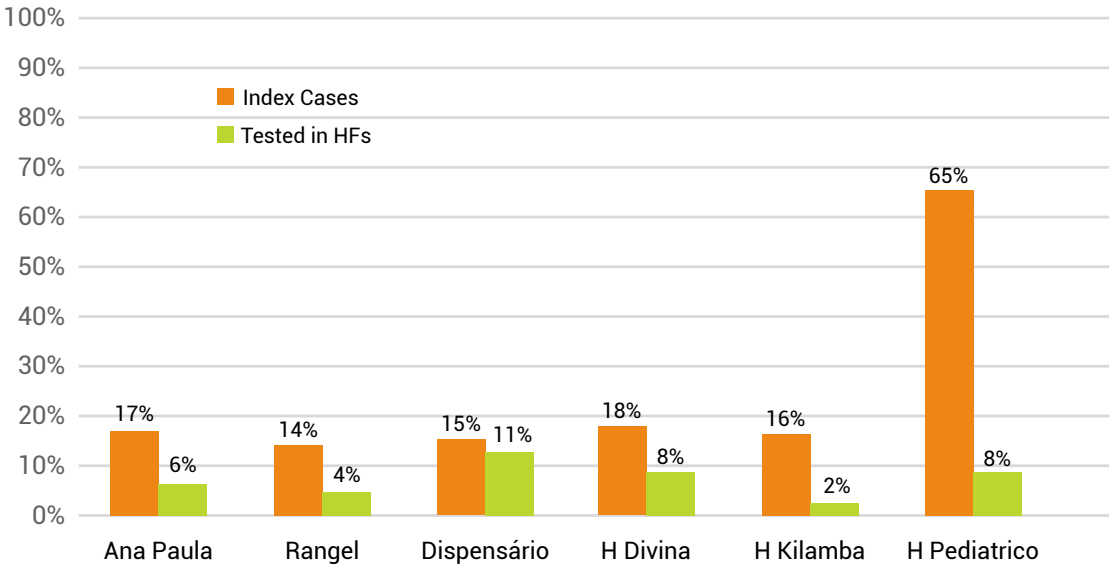


	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec
IC Attended	210	199	199	176	201	213	227	223	237	227	229	192
Tested Contact	316	270	285	254	319	285	293	313	316	279	261	215
Positives	92	79	83	83	89	84	83	70	91	66	55	56
Linked	75	60	68	70	71	64	72	59	67	54	38	34
Positive %	29%	29%	29%	33%	28%	29%	28%	22%	29%	24%	21%	26%
Linked %	82%	76%	82%	84%	80%	87%	87%	84%	84%	82%	69%	61%

Source: Register Books and SIS of the HIV Services-Elaboration: HFA

annex
09

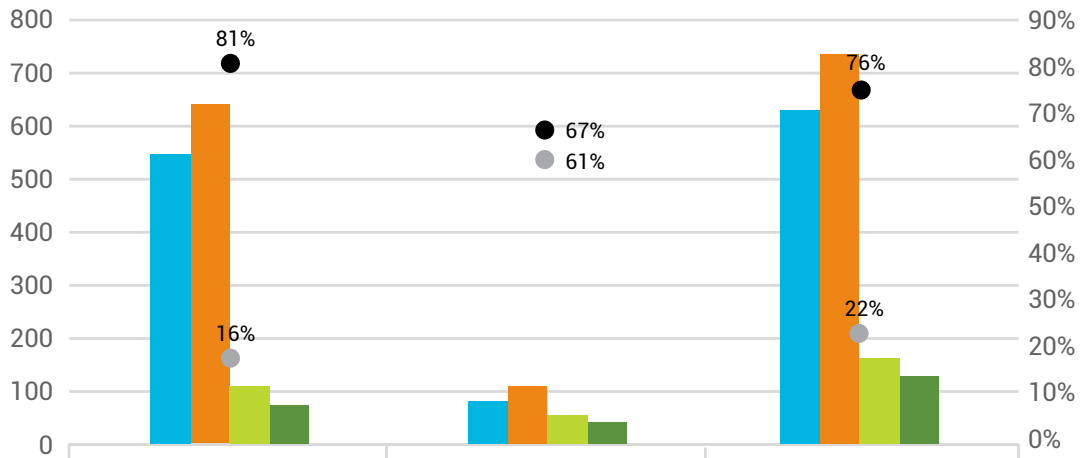
FY2019-Q1 Percent of positive Cases by Index Case VS. Health Facility



Source: Test Register of Index Case Contacts -Elaboration: HFA

annex
10

FY2019-Q1 Index Cases, Contacts, Positives, and linked by Age Group



	Adult Index Cases	Children's Index Cases	Total
Index Cases	550	88	638
Tested Contact	630	103	733
Positives	101	63	164
Linked	82	42	124
Positive %	16%	61%	22%
Linked %	81%	67%	76%

Source: Register Books and Clinic Process of HIV Services from the HFs-Elaboration: HFA

annex
11

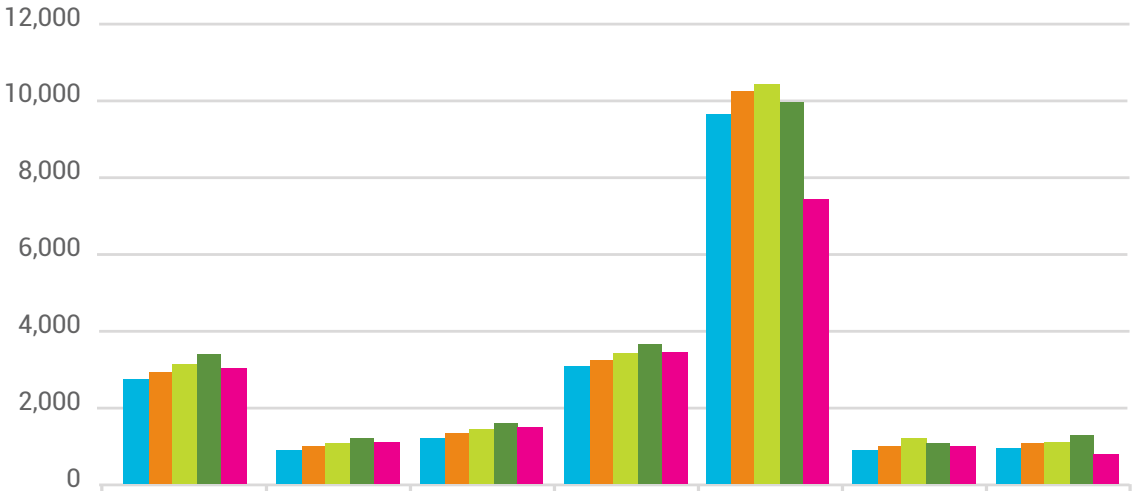
FY2019-Q1 Percent of Index Case Contacts Tested

	HIV +	HIV -	Ind	% HIV +
INDEX CASE >= 15 YEARS OLD				
Spouse/partner	63	212	1	**23%**
Children	9	262	2	**3%**
Extramarital partners	29	55	0	**35%**
INDEX CASE < 15 YEARS OLD				
Parents	61	12	0	**84%**
Siblings	2	28	1	**6%**
INDEX CASE TOTAL				
Spouse/partner	63	212	1	**23%**
Children	9	262	2	**3%**
Parents	61	12	0	**84%**
Siblings	2	28	1	**6%**
Extramarital partners	29	55	0	**35%**

Source: Register Books and Clinic Process of HIV Services from the HFs-Elaboration: HFA

annex
12

FY2018-Q1 to FY2019-Q1 TX_Current Evolution by Health Facility

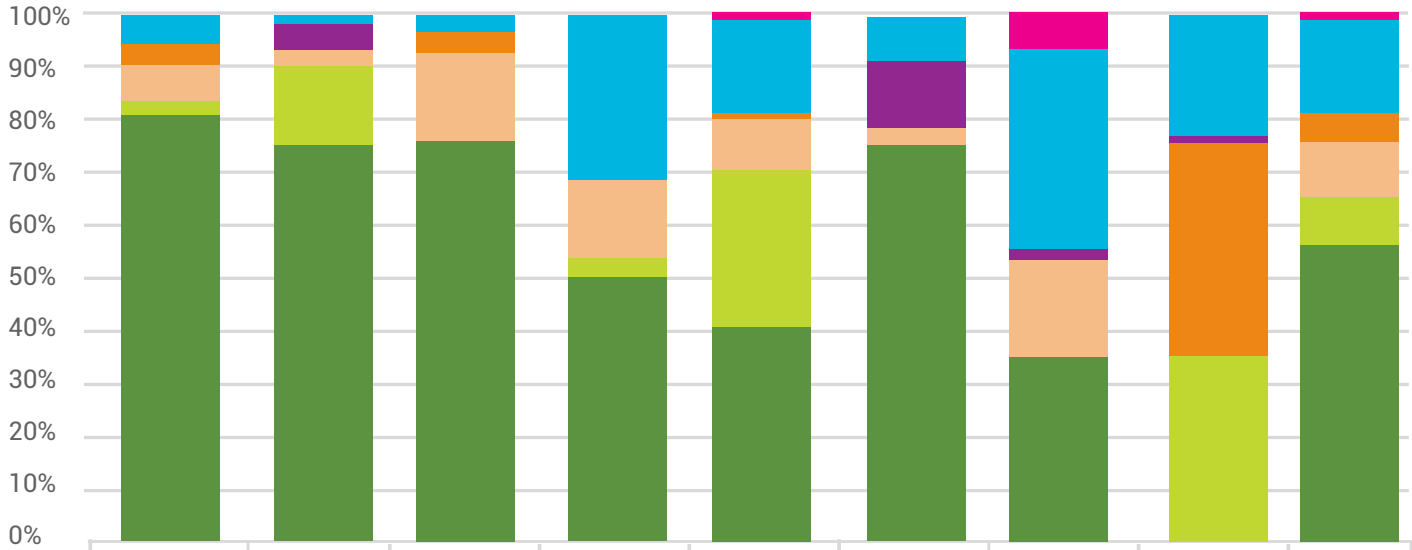


	CS Ana Paula	CS Rangel	Dispensário	H Divina	H Esperança	H KilambaH	Pediatrico
FY18 Q1	2,733	728	891	2,986	9,757	842	1,015
FY18 Q2	2,881	804	933	3,107	10,280	944	1,065
FY18 Q3	3,056	856	1,051	3,216	10,388	982	1,091
FY18 Q4	3,186	956	1,124	3,322	9,975	1,042	1,127
FY19 Q1	2,882	883	1,056	3,296	7,104	973	817

Source: Register Books and SIS of the HIV Services-Elaboration: HFA

annex
13

FY2019-Q1 Record of Positives Following from the Seven Health Facilities

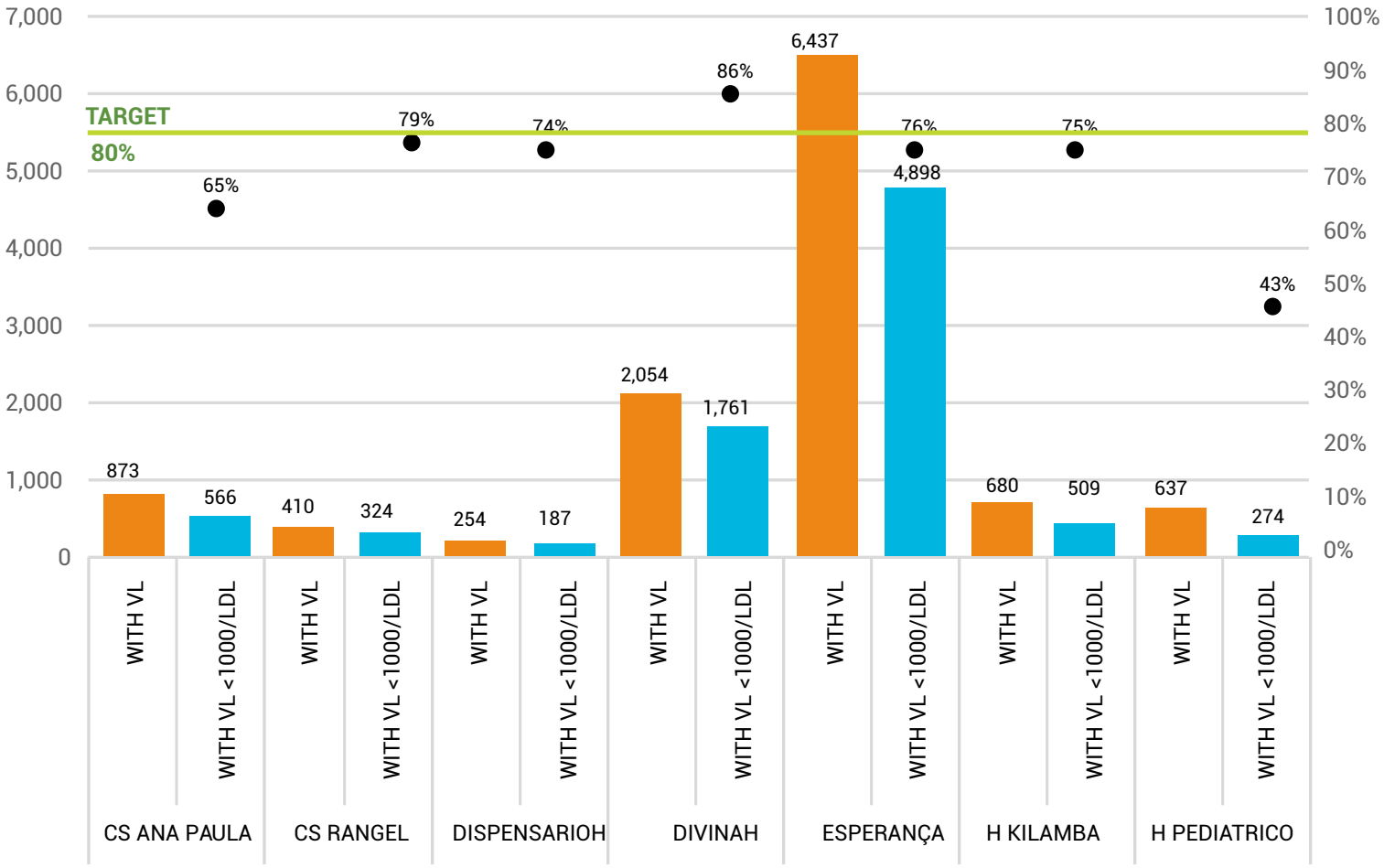


	Ana Paula HC	Rangel HCD	ispensario	Divina H	Esperança HK	ilamba H	Pediatric H < 15y	Pediatrico H >= 15y	TOTAL
Death					3		91		2
Lost	17	1	2	80	30	11	60	26	227
NF	34		4	1	1	13	2	2	30
FwoV	5		3	1	1			37	47
FinHF	24	1	30	33	94		24		125
FwV	6	8	3	5	43			39	104
Linked	20	65	137	30	62	90	59		763

Source: Record of Positives following from the HIV Services in the Health Facilities. FwV: Follow with Verification. FwoV: Follow without Verification. FinHF: Follow in the same Health Facility. NF: Not Followed. Elaboration: HFA

annex
14

FY2019-Q1 TX_PVLS by Health Facility



Source: Register Books of VL, SEGEP and Clinic process of HIV from the HFs-Elaboration: HFA

Quantified products include pills (both contraceptives combined oral/Microgynon pill and progesterone/Microlut), condoms (male and female), injectables (medroxyprogesterone acetate or Depo-Provera), the IUD and implants (Norplant and Jadelle). This forecast covers 2019, which estimates changes in contraceptive per user per year of some products, such as IUDs, injectables, the implant and condoms. These products were the focus of a meeting between PSI and PSM, as shown in the designated tables below.

Considering methods from past quantifications, the method for women of reproductive age (WRA) was chosen. However, this update is only based on what was chosen, highlighting that the U.S. Senate's projection based on WRA for 2019 continued to maintain the current unmet need of 38%. The table below reflects the current situation with this update and estimates contraceptive per user. Condoms are included in this estimation, taking into account the reduction of male condoms from 120 to 50 per user and female condoms from 120 to 23 per user.

Table 1: Current quantification with updated estimates of contraceptive per user

Current					
Product	**Contraceptive per user**	**Unit**	**Unit price (USD)**	**Quantity**	**Cost**
Pill	15	Cycle	0.31	10,151,395	3,146,932
Microgynon (79%)	15	Cycle	0.31	8,019,602	2,486,077
Microlut (21%)	15	Cycle	0.31	2,131,793	660,856
IUD	1	Each	0.57	5,034	2,869
Injectable – Three month	4	Vial	0.57	3,108,081	1,771,606
Implant - Norplant, Jadelle	1	Each	8.50	25,167	213,920
Male condom	50	Piece	0.04	72,689,003	2,907,560
Female condom	23	Piece	0.58	576,499	334,369
			Total cost	**11,524,189**	**25.3**

Table 2: Mix method 1 updated estimates of contraceptive per user

Mix Method 1					
Product	Contraceptive per user	Unit	Unit price (USD)	Quantity	Cost
Pill	15	Cycle	0.31	10,151,395	3,146,932
Microgynon (79%)	15	Cycle	0.31	8,019,602	2,486,077
Microlut (21%)	15	Cycle	0.31	2,131,793	660,856
IUD	2	Each	0.57	9,318	5,311
Injectable – Three month	4	Vial	0.57	3,108,081	1,771,606
Implant - Norplant, Jadelle	3	Each	8.50	75,500	641,750
Male condom	50	Piece	0.04	72,689,003	2,907,560
Female condom	23	Piece	0.58	576,499	334,369
				Total cost	**11,954,461**

Table 3: Mix method 2 updated estimates of contraceptive per user

Mix Method 2					
Product	Contraceptive per user	Unit	Unit price (USD)	Quantity	Cost
Pill	15	Cycle	0.31	10,151,395	3,146,932
Microgynon (79%)	15	Cycle	0.31	8,019,602	2,486,077
Microlut (21%)	15	Cycle	0.31	2,131,793	660,856
IUD	2	Each	0.57	9,318	5,311
Injectable – Three month	6	Vial	0.57	4,662,123	2,657,410
Implant - Norplant, Jadelle	3	Each	8.50	75,500	641,750
Male condom	50	Piece	0.04	72,689,003	2,907,560
Female condom	23	Piece	0.58	576,499	334,369
				Total cost	**12,840,265**

Attachment 1:

Corrective Action Plan- Q1 FY19 Update

Issue Description: USAID requested PSI to present a Corrective Action Plan that outlines areas of improvement.

Desired Outcome: Improved performance of Health for All Project.

Action Plan Sponsor: PMI – USAID

Strategic Action / Activities	Party / Responsible	Resources required	Stakeholders	Constraints	Date due	Update for Q1 FY19
Malaria Case Management						
Training						
Review job aids and technical manuals for accuracy, up-to-date information and presentation of the technical material and suggest improvements, including advocacy for improvements.	HFA R2 Staff	STTA Victor Lara	NMCP Global Fund WHO	NMCP training manuals require updates to ensure quality improvement.	(Q2 – Q3)	Job aids and technical manuals are being updated in accordance with WHO and NMCP guidelines. The revised versions will be submitted for approval to PMI and NMCP in Q3.
Review NMCP Angola training manuals and job aids in malaria case management	HFA R2 Staff	STTA Victor Lara	NMCP Global Fund WHO		(Q2 – Q3)	Victor Lara's second visit to the country was delayed due issues obtaining a vis. Review of training manuals and job aids will start in March 2019.
Attend MCM trainings to assess the quality of trainers to improve technical competency and training delivery.	Global Fund	(Q2 – Q3)	NMCP Global Fund WHO		(Q2 – Q3)	Same comment as above
Develop provider-client communication skills training to add as part of provider case management training (R2)	HFA R2 Staff	STTA Victor Lara and Mathias Pollock	NMCP Global Fund WHO	National malaria trainers (TOTs) also need communication skills training.	(Q2 – Q3)	Same comment as above
Formative Supervisions						

Review supervision plan, supervision tools and supervision skills of HFA staff and propose improvements	HFA R2 Staff	STTA Victor Lara	NMCP Global Fund WHO	NMCP supervision tools are not user friendly.	(Q2 – Q3)	The review of HFA's supervision plan and tools is being implemented, based on a proposal submitted by the STTA (Victor) in Dec/19. The revised version of the plan and tools will be presented to NMCP and PMI for comments and approval, before being applied.
Elaboration of integrated training and formative supervision manual.	HFA R2 Staff	STTA Victor Lara	NMCP Global Fund WHO	The NMCP's supervision tool was identified as too long and cumbersome.	Q2	With technical support from the STTA (Victor) and in close collaboration with NMCP, HFA is developing an integrated training and supervision manual, which should be ready for approval and use in Q3.
Evaluate the formative / supportive supervision tool (NMCP)	HFA R2 Staff	STTA Victor Lara	NMCP Global Fund WHO	The NMCP's supervision tool was identified as too long and cumbersome.	(Q2 – Q3)	NMCP supervisions tools are being revised in collaboration with the NMCP and should be ready to be shared with PMI by the end of Q2.
Improve supervision skills and outcomes, train and provide on-the-job coaching to HFA and stakeholder personnel.	HFA R2 Staff	STTA Victor Lara	NMCP Global Fund WHO	(Q2 – Q3)	(Q2 – Q3)	NMCP supervisions tools are being revised in collaboration with the NMCP and should be ready to be shared with PMI by the end of Q2.
Train provincial and municipal supervisors and malaria focal points on formative supervisions.	HFA R2 Staff	STTA Victor Lara	NMCP Global Fund WHO	The NMCP's supervision tool was identified as too long and cumbersome.	Q3	Same comment as above
Identify and train master supervisors, or trainers or trainers (TOTs), who will continue building supervisors' capacity.	HFA R2 Staff	STTA Victor Lara	NMCP Global Fund WHO		(Q1 – Q4)	Some national malaria trainers are being evaluated during trainings they conduct to identify those that can become TOTs in formative supervision.
Assess the capacity of supervisors to perform supportive supervision.	HFA R2 Staff	STTA Victor Lara	NMCP Global Fund WHO		(Q2 – Q3)	Once a cadre of well-trained supervisors is formed, some of them will become master supervisors for the NMCP.

Advocate for the use of HNQIS as a supportive supervision tool.	HFA R2 Staff	STTA Victor Lara	NMCP Global Fund WHO		(Q1 – Q4)	HNQIS use is going to be advocated for with the MoH once the revised supervision plan and tools are approved and tested in the field. The tools will initially be paper-based and later migrated to electronic versions.
ICCM						
Review current set up of iCCM activities through ADECOS and suggest opportunities to improve the model, including advocacy with the NMCP and FAS (if required).	HFA R2 Staff	STTA Victor Lara	NMCP FAS World Vision UNICEF Mentor		(Q1 – Q3)	Implementation of ADECOS in Lunda Sul and Zaire started in Q3 FY18. PSI has been trying to gather lessons learned by other ADECOS partners, but information sharing is very difficult.
Evaluate iCCM implementation results from PSI and stakeholders and develop an improvement work plan.	HFA R2 Staff	STTA Victor Lara	NMCP FAS World Vision UNICEF Mentor		(Q1 – Q3)	Data collected by ADECOS in two municipalities in Zaire and two in Lunda Sul is still done manually through family notebooks. PSI has been conducting monthly supervision of all four municipalities and collecting data from the ADECOS. Once the KoBoCollect app is approved by FAS and used by the ADECOS, it will speed up the process of analysis and evaluation of results.
Develop recommendations for better coordination between the ministries (MoH and FAS/MAT) and stakeholders.	HFA R2 Staff	STTA Victor Lara	NMCP FAS World Vision UNICEF Mentor	Recurrent lack of communication and coordination.	(Q1 – Q2)	PMI, NMCP, PSI and FAS have been meeting more regularly to improve the communication and coordination of activities, but this has not included other ADECOS partners.
Evaluate iCCM supervision activities and develop recommendations for improvement.	HFA R2 Staff	STTA Victor Lara	NMCP FAS World Vision UNICEF Mentor	Resistance by FAS to change the data collection process with ADECOS.	(Q1 – Q2)	Supervision activities are still focusing on manually collecting data from ADECOS. PSI has been advocating with FAS to improve that process by utilizing a very simple modified KoBoCollect application.
Review data collection tools, supervision tools and job aids, and propose improvements.	HFA R2 Staff	STTA Victor Lara	NMCP FAS World Vision UNICEF Mentor		(Q1 – Q2)	Same comment as above

SBCC: Malaria						
LLIN use: A quantitative and qualitative assessment was conducted in three provinces to evaluate net use and care practices post the mass LLIN campaign (Q2). Results were analyzed (Q3). Based on the results, a costed communication plan was developed using a participatory approach with stakeholders' inclusion (Q3).	HFA Staff Suse Emiliano	STTA Mathias Pollock Vector Works	NMCP PSM Global Fund UNITEL	IRB for the study might cause a delay in field activity, and HFA will start the process as soon as possible to minimize potential delay.	(Q1 – Q3)	Study is under IRB review at JHU. The field work is anticipated to start in mid February. The STTA for campaign development is preliminary scheduled for the second week of April. In the meantime, the PSI communication team is participating in the inter-ministerial SBCC working group to develop a malaria campaign for the first half of 2019.
MiP: Review VectorWorks' assessment and World Learning's additional qualitative study that was conducted. Messages and channels were identified and approved (Q2). Implementation starts via Mentor (2 provinces), RMA (1 province) and PSI (3 provinces) (Q3).	HFA Staff Suse Emiliano	STTA Mathias Pollock	NMCP PSM Global Fund UNITEL		(Q2 – Q3)	A qualitative study is scheduled for February. The campaign development workshop is preliminarily scheduled for the second week of April.
Qualitative study design to validate the findings of literature review in the Angolan environment.	HFA Staff Suse Emiliano	STTA Mathias Pollock	NMCP Reproductive Health/DNSP World Learning RMA		(Q2 – Q3)	Same comment as above
Design na appropriate communications strategy (potentially performed via IPC) in a participatory manner.	HFA Staff Suse Emiliano	STTA Mathias Pollock	NMCP Reproductive Health/DNSP UNFPA UNICEF UNITEL		(Q2)	Same comment as above
Train RMA in the MiP communication and implementation plan, IPC, supervision and other tools.	HFA Staff Suse Emiliano	STTA Mathias Pollock	NMCP Reproductive Health/DNSP World Learning RMA		(Q3)	Same comment as above

Testing and treatment behaviors: Behavior change will focus on providers through improved supervision and training on client communication skills (part of MCM STTA).	HFA Staff Suse Emiliano	STTA Mathias Pollock STTA Victor Lara	NMCP Reproductive Health/DNSP World Learning CENFFOR	NMCP Reproductive Health/DNSP World Learning CENFFOR Adding another module in the curriculum might require approval from the MoH.	(Q2 – Q3)	Job aids for formative supervision will be revised to be user friendly and have tips on communication between the health provider and client. Training manuals will include communication tips for provider-client communication. To be completed in Q2.
SBCC: Family Planning						
Review and participate in the development of SBCC strategies in SRH, with a focus on youth	HFA Staff Eva Fidel Suse Emiliano	STTA Mathias Pollock	NMCP Reproductive Health/DNSP UNFPA UNICEF		(Q1)	A qualitative study is under way. The MoH has participated in the study presentation and the training of interviewers.
Qualitative study (focus groups and in-depth interviews) among adolescents.	HFA Staff Eva Fidel Suse Emiliano RMA	STTA Mathias Pollock	NMCP Reproductive Health/DNSP UNFPA UNICEF		(Q1 – Q2)	As above. Study to be finalized in February.
Workshop to analyze the qualitative study findings and develop the SBCC campaign plan, including messages' effectiveness and the sustainability of SBCC interventions.	HFA Staff Eva Fidel Suse Emiliano	STTA Mathias Pollock	NMCP Reproductive Health/DNSP UNFPA UNICEF Youth Health Providers UNITEL		(Q2)	The workshop is scheduled for the second week of March.
Campaign and approval	HFA Staff Eva Fidel Suse Emiliano RMA		NMCP Reproductive Health/DNSP UNFPA UNICEF		(Q2)	The campaign will be developed in a March workshop and prototyped immediately.
Campaign launch	HFA Staff Eva Fidel Suse Emiliano RMA		NMCP Reproductive Health/DNSP UNFPA UNICEF Youth Health Providers UNITEL		(Q2)	The campaign will have a soft launch after the workshop in March. The prototype phase is included in the campaign launch.
Campaign implementation and continuous monitoring	HFA Staff Eva Fidel Suse Emiliano RMA	STTA Mathias Pollock	NMCP Reproductive Health/DNSP UNFPA UNICEF Youth Health Providers UNITEL		(Q3 – Q4)	As scheduled

Attachment 2:
Local NGO Capacity Development Plan (update)

Background

Since the start of Health for All (HFA) project, Rede Mulher Angola (RMA) has been receiving capacity building support from PSI/Angola. To understand the overall situation at RMA, a SWOT analysis was conducted between 24-25th July 2017. A summary of the findings is presented below:

Strengths:

- Network of more than 80 local organizations
- Experience in implementing community intervention
- Strong partnership with governmental organizations such as: the Ministry of Social Action, Family and Women's Promotion (MASFAMU), national agencies (Group of Women Parliamentarians) and international agencies (UNWOMEN)
- Strong leadership and advocacy skills on the fight against gender-based violence

Weaknesses:

- Missing a solid organizational strategy for the short, medium, and long term
- Staff with little experience in key areas such as: SBCC human resources, finance, procurement, logistics, and monitoring and evaluation.

Opportunities:

- Current HFA grant

Threats:

- Dependence on a single source of funding and lack of external donors
- Difficulty in finding and maintaining qualified human resources in the organization
- Lack of governmental financial support for national NGOs

The result of the SWOT analysis was used as the base to develop the Capacity Building Plan for RMA. Given the need, PSI/Angola staff has been providing capacity building to improve the areas of finance, human resources (HR), information technology (IT), procurement and logistics, and program management.

Monitoring of the Capacity Building Plan

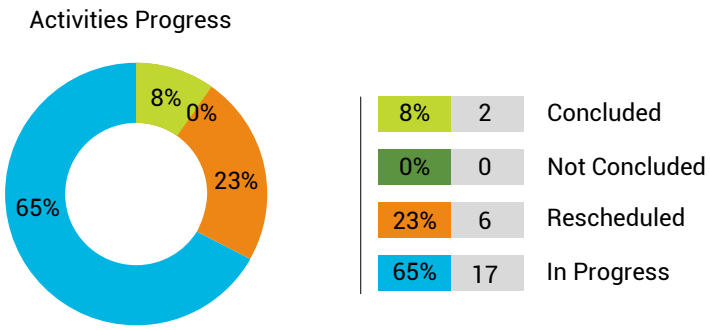
To track the overall progress made in building capacity at RMA, PSI created a monitoring plan that is updated quarterly. The monitoring plan has different sections related to the areas of improvement presented above. This plan (an Excel spreadsheet) helps calculate the progress made in each area.

The status of capacity building activities are measured according the targets, percentage achieved, and deadlines. The status of each activity is color-coded as showed below:

	Green dot - complete
	Dark green dot - Not Completed
	Orange dot – Rescheduled
	Blue dot- in progress (here includes those activities whose deadline is the end of FY19).

Below is the status of the overall progress of the Capacity Building section. The Excel spreadsheet records all the activities and, according to their status, generates a chart that allows us to analyze the overall status of the progress. The results graph is displayed below:

Results achieved during reporting period (Q1 FY19)



- The chart above was generated according to the progress made in each one of the priority areas. In Q1 FY19, 8% of the activities were concluded, 23% activities were rescheduled for Q2 and 65% of the activities are in progress (ongoing). It is important to mention that the table includes quarterly and yearly targets. A summary of the main achievements includes:

Finance:

- Finance Manager Hired - PSI's Departments of Finance and HR helped RMA to identify and hire an experienced Finance Manager to lead RMA's finance department. The new finance manager received on-job coaching from PSI's finance department.

Human Resources

- Revision of the RMA organogram – Since the program is growing, the need for personnel is also growing. Hence, RMA's organogram needed revision to fit the current needs of the program implementation. The revised organogram will be finalized in Q2.

Procurement

- Implementation of the Procurement Manual – The department of logistics and operations is conducting monthly supervision to monitor the use of the new procurement manual. PSI's procurement department has been providing continuous support to RMA's procurement department.

Programmatic

- Capacity building plan updated – Based on the targets for FY19, some updates were made to the capacity building plan. The most recent capacity building plan is a continuation of the FY18 capacity building plan with some improvements, to ensure implementation and continuity of the plans/ capacity and skills built during the previous fiscal year.

- RMA began a new SBCC intervention – A consultant was hired to conduct a qualitative study among adolescents to identify youth sources of information. The result of this study will be the base to create the new communication campaign.

Attachment 3:

ADECOS SUCCESS STORY IN ANGOLA 2018 - MALARIA

Fig1. Graça in her typical attitude of assisting the ADECOS supervisor in delivering important key messages to her colleagues about malaria prevention strategies in the community.

Fig2. Working with one of the families she assists in her community.

Graça Mourão is a young determined woman in her 20´s, living in the municipality of Tomboco, part of Zaire province in the north of Angola. As an active woman in her community, she was appointed by community elders and the local administration to integrate the community development workers program (ADECOS) in early 2018. Since then, she has been supporting families in community development issues, including malaria prevention and case management.

To fight the malaria vector, Graça is active in communicating with her community members about eliminating residual waters and promoting the use of bed nets on a daily basis.

Fifty-four families are supported by her in her home village called Kingombo. Between September and December 2018, Graça identified 28 new fever episodes from which 23 children under five years old were diagnosed with malaria and successfully treated, while the other 5 malaria-negative children were referred to a nearby health unit for follow-up. She has set a good example among other ADECOS through the quality of her work and data collected, being a generous and thoughtful team leader of ADECOS during formative supervisions, when she actively supports her supervisors as if she were one of them, delivering key messages and helping strengthen the quality of data being collected by other ADECOS.

According to Graça, the ADECOS program is an answer to the community needs. Her desire is that the program expands to all of Angola to help people, especially young children, reduce the burden of malaria on their lives.