Angola

Operational Plan Report

FY 2010

Operating Unit Overview

OU Executive Summary

HIV/AIDS in Angola

Angola's population is an estimated 17 million with 62% of the population under the age of 24. Thirty five percent of the population resides in the urban areas[1] with extreme disparity in wealth between the urban and the rural populations in the country. Despite having a GNP per capita of US$1,930, 27% of the population is living on less than US$2 per day. The estimated infant mortality rate for Angola is 125 per 1,000 live births and a total fertility rate of 6.6 children per women aged 15-49.

With an estimated 2.1[2] - 2.5[3] percent of the adult population being HIV positive, Angola has the lowest rate of HIV prevalence in southern Africa. During the 1975-2002 Angolan civil war, travel within the country and with neighboring countries was nearly impossible, thus impeding the spread of HIV/AIDS. However, movement has become less restricted after the war, and the likelihood of HIV reaching these once-isolated communities has increased. HIV prevalence among pregnant women remained fairly stable at 2.4 percent in 2004 and 2.5 percent in 2005[4], with an increase to 3.1% in 2007[5]. In addition, data collected from women attending antenatal clinics (ANC) suggest that the intensity of the HIV epidemic varies greatly between provinces, with the highest rates of HIV infections occurring in the areas bordering Namibia (9.3%), and the lowest rates in central Angola (around 1%)The main mode of transmission is heterosexual intercourse and multiple and concurrent sexual partnerships are thought to be frequent. Studies on female sex workers (FSW) in Luanda showed that the HIV prevalence of this at-risk population is approximately 23.1%[6], suggesting a strong potential for bridging HIV infection into the general population. In 2006, the National Institute responsible for fighting HIV/AIDS[7] estimated that 400,950 people living in Angola were HIV positive[8]; with only 25%[9] of those in need of treatment receiving antiretroviral therapy (ART).

[1] UNDP, Human Development Report, 2004
[2] INLS, Annual HIV surveillance Report, 2008
[3] UNAIDS 2005 ANC data
[4] UNAIDS (2006)
[5] INLS (2007)
[6] INLS 2006
[7] INLS 2006
[8] WHO/UNAIDS/UNICEF Towards Universal Access, December 2007
[9] WHO/UNAIDS/UNICEF, Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector, Progress Report, September 2009:

The HIV/AIDS program in Angola has undergone major development and expansion over the past several years; services are slowly growing and awareness about HIV/AIDS among the general population is rising. However, HIV risk perception is low and up to 32% of youth initiate sexual intercourse before the age of 15[10]. The lack of knowledge in HIV prevention, early sexual debut, and low condom use underscore the need for the government of the Republic of Angola (GRA) to focus its national HIV prevention strategy on the general population and youth, as well as specific vulnerable and at risk groups such as commercial sex workers, truckers and the military.

A significant weakness of the HIV program is its limited information on baseline demographic, health, and HIV indicators. The lack of data creates a barrier to address the epidemic through evidence-based programming. The last national census took place before the civil war in 1970, and population-based surveys, including the demographic health survey, have never been conducted. The absence of a functional health system in the country is also a major concern. Fortunately, the GRA and other donors[11] recently increased their focus in the areas of HIV prevention, strategic information, and health systems. The USG will continue to support the improvement of health management in direct collaboration with the Provincial Health Directorates of 8 high prevalence provinces (Luanda, Cunene, Kuando Kubango, Huambo, Lunda Norte, Lunda Sul, Cabinda, and Uige). Support through USG Angola's Fiscal Year (FY) 2010 Country Operational Plan (COP) aims to work in collaboration with the GRA national HIV/AIDS strategy and maximizes its limited resources by concentrating its effort on prevention and health system strengthening. Implementation of the Partnership Framework (PF) will increase the response throughout the country and better position Angola to address the epidemic over the long term by facilitating greater sustainability and GRA ownership.

Prevention

PEPFAR Angola's FY2010 COP sexual prevention portfolio represents a strengthened and continued focus on quality programming consistent with available data on Angola's epidemiological profile, while also increasing data to help inform future programming. HIV is transmitted primarily through multi-partner heterosexual encounters, with a male-to-female ratio of 0.8:1, indicating that women are more likely to be infected than men.

[10] UNAIDS 2008

[11] Angola's HIV National Strategic Plan (2007-2010); INLS 2008 Activity Report; UN Development Assistance Framework Strategy for Angola (2009-2013); National Health System Assessment from 2005 (USAID funded); Round 9 Global Fund Proposals; Angola Donor Coordinating and Aid Effectiveness Report (2009-2013-World Bank); World Bank HAMSET Report; and the UNAIDS Annual Monitoring and Reporting on the Health Sector Response to HIV/AIDS, 2009.

Angola's ANC data estimates HIV prevalence at 2.1% of the population aged 15-49, and 2.6 % for the age group 15 – 24, with pockets of concentrated epidemic along its borders with high HIV prevalence countries. Additional factors that increase the risk of contracting HIV include transactional sexual activity and multiple concurrent partners (23% of youth reported having two or more partners in the last three months). Condom use remains low with only 32.6% of the general population reporting using a condom during the last sexual intercourse and 55% of youth using a condom with their last casual partner, 37% use with a non-married permanent partner and 19% with a marital partner. Furthermore, the perception of risk among youth is low, with only 9% of youth classifying themselves as being at high-risk of contracting HIV. Similarly, more than half of VCT clients reported not using a condom in the last three months, 35% reported sometimes using a condom, and 7% reported always using a condom. Of males tested for HIV at VCT sites, 28% reported having concurrent partnerships. Only 22.7% of the population between 15 and 49 years knew the principal transmission modes of HIV and rejected false ideas about the transmission of the virus[12] . A 2006 INLS study showed that commercial sex workers nationally have an estimated 26% prevalence rate.

The main focus of the USG approach to sexual prevention in 2010 is to promote the adoption of alternative sexual behaviors that will lead to HIV prevention. During 2010, the USG prevention strategy will continue to focus its efforts on reducing high-risk behaviors, including low and inconsistent condom use, early sexual debut, multiple concurrent partnership (MCP), transactional, trans-generational and commercial sex, gender-based violence (GBV) and sexual risk associated with alcohol use. USG Angola will also work collaboratively with the GRA to integrate preventive services, such as PMTCT, into family planning, maternal and child health, and malaria services.
Specific areas of focus on general, vulnerable and high-risk populations include:

Youth: Abstinence promotion, including the delay of sexual activity or secondary abstinence, fidelity, reduction of multiple and concurrent partners, condom promotion and distribution (as appropriate) and related social and community norms that impact these behaviors.

Most At-Risk Populations (MARPs) and other vulnerable populations: VCT, and STI/HIV prevention sites will be expanded at points accessible to MARPs (e.g. transport routes, communities surrounding military bases, bars, etc.), and will include rapid testing and counseling, outreach for HIV+ follow up, customized messages, condom programming, distribution and social marketing that emphasizes consistent and correct use of condoms that will focus on commercial sex workers and truckers.

Uniformed personnel: Prevention efforts with the military will be expanded and strengthened to reach additional uniformed personnel (i.e. border patrol, police, etc.) with increased services.

General population: The main objectives of the prevention package for the general population are to improve the understanding of the risks of HIV infection, scale - up

[12] HAMSET, 2007

HIV prevention and health promotion, expand health services, including condom programming and BCC/IEC messages, and scale up VCT, STI, and reproductive health services referral at provincial, municipal levels and in communities surrounding military bases.

Prevention of mother to child transmission (PMTCT) is one of the major priorities in the Angola National AIDS Strategic plan (2007 – 2010), with the goal of achieving 80% coverage rate for HIV-positive pregnant women to receive ART for PMTCT. The USG program capitalizes on increasing national attention to PMTCT by expanding services and increasing access to pregnant women in Angola. The overall uptake of PMTCT is slow as ANC coverage remains at only 45% of pregnant women having assisted deliveries by health personnel. In addition, only 10% of pregnant wo**m**en living with HIV have received antiretroviral therapy for PMTCT[13]. However, PICT[14] was adopted in 2009 to strengthen PMTCT, which led to improvements in the physical infrastructure for service delivery and training for health care workers. These improvements, coupled with coherent communication strategies, resulted in an increased demand for PMTCT services. The GFATM supports the procurement and distribution of ARV drugs for PMTCT and VCT programs in the maternity wards, hospitals and prenatal health services, while UNICEF is piloting PMTCT interventions in provincial hospitals. The USG will be working closely with international partners to develop a comprehensive, evidence-based program for pregnant women. Furthermore, USG Angola has strengthened its collaboration with the Presidential Malaria Initiative (PMI) through the integration of ANC and malaria services in recent years.
During 2010, a PMTCT assessment will be planned and conducted to inform the scale up process. HIV/AIDS activities, including PMTCT will continue in the eight provinces supported by the USG and will be further scaled up in two provinces, Luanda and Cunene in collaboration with the MOH and provincial health directorates. The USG will coordinate with the GRA, including the MOH, provincial, and municipal authorities, to scale up new health centers with PMTCT services, to increase the number of pregnant women to be tested and counseled (at least 80% over five years) and children born to positive mothers with negative status. In addition, an emphasis will be placed on the expansion of family planning use among women after delivery. Early Infant Diagnosis (EID) implementation will also be integrated into existing PMTCT services.

Health System Strengthening (HSS)

According to the National HIV/AIDS program, only 15% of public health facilities provided HIV testing and counseling services and only 6% offered post exposure prophylaxis (PEP) on site in 2008[15]. The overall clinical and managerial capacity of the health workforce remains low. High turn over rates and shortage of trained health personnel at both at the national and sub-national levels is a concern. The main focus in

[13] UNAIDS 2008
[14] Provider Initiated Counseling and Testing
[15] INLS, 2008

FY2010 is to strengthening capacity and increasing country ownership for an effective national response to combat HIV/AIDS.

Institutional Capacity Building. In support of the PF goal of promoting sustainability and country ownership, USG will provide technical assistance and institutional capacity building to civil society partners for grant writing, management and supervision, leadership, financial management, and monitoring and evaluation (M&E).

The USG will specifically support the drafting of the National Strategic Plan 2010-2014 extension and support the MOH in providing in-service management and supervisory training for existing health care workers (doctors, nurses, nurse-midwives, medical assistants, laboratory technologists and pharmacy technicians). It will also assist the MOH in developing policies for task shifting to nurses and other healthcare professionals and in expanding quality control system at municipal and provincial levels to strengthen supervision of community health workers. The USG will help strengthen community health worker capacity to promote PMTCT through training and provide technical assistance to the MOH in the development of a PMTCT expansion strategy. Implementation of the Field Epidemiology and Laboratory Training Program (FELTP) will take
place in FY 2010. The provision of technical training in epidemiology and laboratory skills for local public health professionals will 1) enhance retention of health care providers through specialization opportunities; 2) increase the number of qualified professionally trained health care workers through short and long term trainings ; 3) strengthen the capacity of health and training institutions to meet accreditation standards; and 4) build human resources to support expansion and decentralization of the laboratory network for the enhancement of country ownership.

The USG envisages supporting an agenda of health systems management, including the provision of TA in the areas of finance and planning, national health accounts and gap analysis of the MOH. It also supports the policy formation of MARP-friendly services, revision of pre-service and continuing education curricula for HIV/STI, reproductive health and family planning, and the implementation of national guidelines for TB/HIV co-infection.
USG will also support the GRA to address key operational and organizational challenges to providing high-quality blood service in Angola. In partnership with CDC and Chevron, Safe Blood for Africa (SBFA) will conduct training in Blood Donor Management Systems and assist with the delivery of blood safety training activities for provincial medical personnel in achieving 100% voluntary non-remunerated blood donors (VNRBD). A strategic plan of action for the development and delivery of a provincial blood safety system will also be developed.

Blood Safety and Laboratory Support.

Angola's health services are compromised by a chronic shortage of safe blood for transfusion. The national blood service collects 20,000 units of blood per annum—one third of the national demand. A laboratory network system is not in place to support a sustainable response in most HIV/AIDS programmatic areas, including patient follow-up and adherence monitoring.

In response to these gaps, PEPFAR Angola will focus its efforts in promoting community awareness, mobilization and increase of voluntary non-remunerated blood donations (VNRBD) and improvement of blood screening through training geared at testing for transmittable infections (TTI), materials handling, and management of blood donors.

The USG will support the development of a well structured and effective laboratory network that aims to ensure appropriate policies on laboratory practices and quality assurance measures for accreditation according to international and national standards. USG will also support "on-the-job" training to build the capacity for sustainable and quality laboratory programs.

Strategic Information (SI). Given the dearth of available data on the HIV epidemic in Angola, the USG will support efforts to improve the overall strategic information system. It will provide assistance in tracking and managing training needs of the health public sector. To improve human resource management, the USG will collaborate with the MOH and INLS to conduct a HSS assessment to develop the Human Resources Strategic Plan and Human Resources Information System in high prevalence zones.
The USG will provide SI TA to the INLS for the harmonization of national indicators and to improve data recording and reporting systems. As the newest INLS estimates on HIV indicators become available in mid-February 2010, the USG will reassess the PEPFAR programmatic portfolio to better align our efforts with the new government data, and the need for reprogramming some of the national and direct indicator targets is likely.
The USG will continue to support the national ANC survey, behavioral surveillance surveys (BSS) for high-risk populations, Priorities for Local AIDS Control Effort (PLACE) studies in mapping HIV transmission "hot spots", and HIV incidence studies. The USG will also strengthen efforts at the national and provincial levels to facilitate HIV-infected TB patient management, HIV surveillance in TB patients, and monitoring of essential HIV/TB program functions and outcomes.
The USG support in SI will pay careful attention to the capacity of the MOH and other partners to ensure that information generated through activities will be used for decision making related to future planning and policy development of HIV-related programs.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV						
Adults 15-49 HIV Prevalence Rate						
Children 0-14 living with HIV						
Deaths due to HIV/AIDS						
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months						
Estimated number of pregnant women living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS						
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living						

with HIV						

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

Redacted

Public-Private Partnership(s)

(No data provided.)

Surveillance and Survey Activities

Name	Type of Activity	Target Population	Stage
Behavioral Surveillance Survey with Biological Markers for HIV and Syphilis among Men who have sex with Men in Luanda, Angola	Population-based Behavioral Surveys	Men who have Sex with Men	Publishing
Behavioral Surveillance Survey with Biological Markers for HIV and Syphilis among Miners in Angola	Population-based Behavioral Surveys	Migrant Workers	Planning
Behavioral Surveillance Survey with Biological Markers for HIV and Syphilis among Prisoners in Angola	Population-based Behavioral Surveys	Other	Implementation
Behavioral Surveillance Survey with Biological Markers for HIV and Syphilis among Truckers in Angola's transportation corridor	Population-based Behavioral Surveys	Mobile Populations	Implementation
Behavioral Surveillance Survey with Biological Markers for HIV and Syphilis among Uniformed Service Members in Angola	Population-based Behavioral Surveys	Uniformed Service Members	Other

Behavioral Surveillance Survey with Biological Markers for HIV and Syphilis among Young Women engaged in Transactional Sex along the Angola-Namibia Border	Population-based Behavioral Surveys	Female Commercial Sex Workers	Publishing
PLACE	PLACE	General Population	Data Review

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHCS (State)	GAP	GHCS (State)	GHCS (USAID)	
DOD			1,300,000		**1,300,000**
HHS/CDC		3,000,000	3,655,000		**6,655,000**
HHS/HRSA			200,000		**200,000**
USAID			5,145,000	4,400,000	**9,545,000**
Total	**0**	**3,000,000**	**10,300,000**	**4,400,000**	**17,700,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency					Total
	DOD	HHS/CDC	HHS/HRSA	USAID	AllOther	
HLAB		460,000				**460,000**
HMBL		700,000				**700,000**
HVAB	80,000			1,745,000		**1,825,000**
HVCT	300,000			350,000		**650,000**
HVMS	200,000	3,490,000		1,195,000		**4,885,000**
HVOP	200,000			3,475,000		**3,675,000**
HVSI		1,055,000		550,000		**1,605,000**
HVTB		150,000				**150,000**
MTCT				700,000		**700,000**
OHSS	520,000	800,000	200,000	1,530,000		**3,050,000**
	1,300,000	**6,655,000**	**200,000**	**9,545,000**	**0**	**17,700,000**

Budgetary Requirements Worksheet

(No data provided.)

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Biomedical Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HMBL	700,000	
Total Technical Area Planned Funding:	**700,000**	**0**

Summary:
6. Blood Safety (HMBL) TAN
Context and Background
Angola is a post-conflict country recovering from a prolonged civil war, which ended in 2002. This devastating civil strife decimated the health infrastructure. Despite important GRA efforts and significant external assistance, Angola's health system still needs significant development as it does not provide adequate health care for the population. The country has 18 provinces. Most public resources are concentrated in the tertiary and secondary health care levels, leaving primary and rural health care centers with minimal support. Only 15% of the health work force provides services in rural areas, where over half of the population lives. The diversion of the nation's resources to fight the war and massive population dislocations led to sustained high levels of poverty, with 21% of the population now living in extreme poverty. This poverty, coupled with low access to health services, translates to poor health conditions, particularly for women.
Angola's population is an estimated 17 million with a HIV prevalence estimated at 2.1% among the population aged l5-49. Sixty-two percent of the population is under 24 years old. During 2004-2007, prevalence among young pregnant women rose from 2.7% to 3.1% (ANC 2005, 2007). Angola is bordered by the high-prevalence countries of Namibia and Zambia. Though Botswana does not border Angola directly, the two countries are separated only by a 30 kilometer stretch of uncontrolled land, which is concerning since the increased movement between the two populations could lead to increased transmission. A review of estimated HIV prevalence by province reveals significantly higher rates in Cunene along the border with Namibia (9.4%). Luanda and Cunene are two geographic areas with a high concentration of MARPs.
The HIV/AIDS program in Angola has undergone major development and expansion over the past several years; however, it has not developed a systematic basis to determine the characteristics of the pandemic. In line with government policy to decentralize decision-making to sub-national levels, provincial and national forums play important roles in implementing HIV/AIDS strategies and recommendations, and contribute to national and regional development planning. Since each province is unique, institutional capacities, needs, and progress in implementing HIV/AIDS strategies and the "Three Ones" principles differ considerably between them. Therefore, programmatic responses are tailored to local realities. This is particularly important in rural and remote districts of the country, which pose considerable challenges in scaling-up interventions.
Challenges/Accomplishments in 09
According to a WHO Study (2004) 12% of the donated blood in Angola came from unpaid volunteers. It is widely accepted that the lowest risk and therefore the safest blood comes from Voluntary Non-Remunerated Blood Donors (VNRBD). Blood safety is a critical factor in the fight against HIV/AIDS and the treatment of Anemia. In Africa, 65% of all transfusions are given to pregnant women and children.

Specifically in Angola, 70% of the available blood supply is provided to children with severe anemia caused by Malaria infection. There is a critical shortage of safe blood available to meet the clinical needs of the population in the Provinces of Angola. The national blood service collects approximately 20,000 units per year, one third of the estimated need (60,000 units in 2009). Furthermore, an alarming issue was the reliance on family blood donors with little disease monitoring of the donated blood. This is not only a high risk practice, because testing is rare among these blood samples, it also fails to provide an adequate inventory of blood to meet clinical needs for emergencies. An area that will require effort and attention in all blood services in Angola is that currently no External Quality Assurance (EQAS) is in place to ensure that donated blood is tested for HIV (and other Transfusion Transmissible Infections (TTI's)) in a systematic manner. Although coordinated by the CNS in Luanda, blood services in Angola remain fragmented with important elements of the country's health care service sourcing for blood outside of the CNS. An extensive overhaul in the current infrastructure is imperative to improve the safety of donated blood and ensure safe transfusions, which can be addressed by the training of health laboratory professionals to guarantee the security of blood supplies, services and products.
To improve blood safety, the MOH/CNS is currently working with the USG, GFATM, the private sector, and Safe Blood for Africa to train medical personnel and blood service staff at the provincial level as well as in the proper use of blood product, to strengthen information systems, and to explore commitments for site renovations. The European Union resources contributed to the procurement of equipment to support infrastructure requirements for upgrades of designated provincial blood centres and hospital blood banks. With this collaboration in place, the MOH/CNS is positioned to expand efforts to ensure an adequate supply of safe blood for transfusion through VNRBD and other interventions.
With USG funding, SBFA commenced a pilot project in Kwanza Sul, Angola. This pilot project consisted of (3) phases of training activities for blood service staff to develop key elements for a model provincial blood service and aims to develop a pilot blood safety program to demonstrate that VNRBD is viable in Angola's provinces. Preliminary results indicate that the program will exceed key expected outcomes which anticipated 25% VNRBD´s as a percentage of the total number of blood donations in year 1. In August 2009, 36% of blood donated in Sumbe was sourced from VNRBD´s. By September 2009, 92% of blood was donated by VNRD´s. Another major accomplishment is the establishment of Monitoring and Evaluation criteria prior to starting the program training activities; which are in alignment with PEPFAR Blood Safety program indicators. There are currently thirty-seven individuals trained in the principles of quality Management, in the specific areas of blood safety.
Goals and strategies for 2010
The FY 2010 COP strategies for Blood Safety are linked directly to the Partnership Framework and the Partnership Framework Implementation Plan goals. Specifically, Goal 2: Reduce the spread of the HIV epidemic, by increasing the availability and access to safe blood. In FY10, partnering with CDC and Chevron, SBFA will conduct trainings in Blood Donor Management Systems, as well as vigorous Monitoring and Evaluation. The program will provide continuity and expand on work currently in progress in Luanda, and the provinces of Kwanza Sul and Kuando Kubango. As a result of the public-private partnership between Chevron, the USG, the GRA, and SBFA, blood safety services will be expanded to Cabinda to promote community awareness of blood donation and to ensure that proper procedures are being utilized to ensure a safe and sufficient blood supply for the people of Cabinda Province. The SBFA will assist with delivering a (central) training activity to benefit Provincial Blood Service Staff in seventeen provinces (2009), and training of medical personal (2010) and then specifically provide training in Cabinda Province to promote community awareness and to mobilize increased numbers of VNRBD.
• The USG will provide direct technical assistance to support GRA to address the existing program challenges and needs by demonstrating that a voluntary blood donor program is possible and sustainable, in Kwanza Sul; and ultimately other provinces in Angola. The expected successes of this program are the potential to address critical shortages of safe blood in neighbouring Provinces. The SBFA will provide training to support the GRA in strengthening blood service activities where these relate to HIV and Hepatitis prevention, treatment of malaria, and maternal death due to severe haemorrhage.

In addition, the USG will provide training in Blood Donor Management Systems, through leveraging other

funded blood donor recruitment activities in Angola (such as the partnership with Chevron which focuses on Luanda and Cabinda); achieving 100% VNRBD as a result of equipping staff with the requisite knowledge, skills and a strategic plan of action for the development and delivery of a provincial blood safety system. A central element in VNRBD recruitment focuses on the importance of targeting young people to become long term blood donors. The youth concept is based around innovative strategies known as Club 25, which is an evidence based program to motivate young donors. Club 25 members will be encouraged to become voluntary non-remunerated blood donors as an affirmative gesture to save the life of another. Members pledge to donate blood at least 25 times in their lifetime and stay committed to remaining HIV free.
In FY 2010, the USG will support training in Quality Management Systems (QMS), in the area of Blood Safety, specifically providing systems training that align with the national testing strategy aimed at improving the technical performance of HIV testing and external quality assurance. QMS training and follow up will be conducted in Luanda, Kwanza Sul, Kuando Kubango and Cabinda, covering training in proper procedures for testing, processing, storage and distribution, and safe clinical transfusion practices. The QMS trainings will be provided by expert teams intended to engage the MOH staff, the CNS in Luanda, and the provincial blood centre staff in Kwanza Sul, Cuando Cubango, and Cabinda. The subject matter expert team will be led by the Chief Training Officer for Safe Blood for Africa.
The USG intends to provide Blood Safety M&E trainings to establish agreed upon indicators which will reflect performance and adhere to the PEPFAR next generation indicators. The aim of the training is to achieve compliance and improve the quality of data collection which will strengthen the M&E plan. The training will support the key following objectives:
• HIV prevention, including training staff in proper blood safety techniques;
• Promoting education of at-risk risk through proven youth strategies, such as Club 25;
• Training in Quality Management Systems (QMS)

Additional FY 2010 activities include:
• Supporting centrally located training activities in Luanda to improve service development in Angola, particularly in the areas of quality management of blood donors, materials handling and testing for transmittable infections (TTI);
• Supporting situational analysis of selected provincial blood services. The assessment will review the infrastructure and technical capacity and existing or potential community networks that could support VNRBD;
• Training to promote VNRBD;
• Training, including principles of Quality Management Systems, in specific areas of blood safety, including monitoring & evaluation.

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Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	650,000	
Total Technical Area Planned Funding:	**650,000**	**0**

Summary:
8. Counseling and Testing (HVCT) TAN
Context and Background
Angola is a post-conflict country recovering from a prolonged civil war, which ended in 2002. This devastating civil strife decimated the health infrastructure. Despite important GRA efforts and significant

external assistance, Angola's health system still needs significant development as it does not provide adequate health care for the population. The country has 18 provinces. Most public resources are concentrated in the tertiary and secondary health care levels, leaving primary and rural health care centers with minimal support. Only 15% of the health work force provides services in rural areas, where over half of the population lives. The diversion of the nation's resources to fight the war and massive population dislocations led to sustained high levels of poverty, with 21% of the population now living in extreme poverty. This poverty, coupled with low access to health services, translates to poor health conditions, particularly for women.

Angola's population is an estimated 17 million with a HIV prevalence estimated at 2.1% among the population aged l5-49. Sixty-two percent of the population is under 24 years old. During 2004-2007, prevalence among young pregnant women rose from 2.7% to 3.1% (ANC 2005, 2007). Angola is bordered by the high-prevalence countries of Namibia and Zambia. Though Botswana does not border Angola directly, the two countries are separated only by a 30 kilometer stretch of uncontrolled land, which is concerning since the increased movement between the two populations could lead to increased transmission. A review of estimated HIV prevalence by province reveals significantly higher rates (estimated at 9.4%) in Cunene along the border with Namibia. Luanda and Cunene are two geographic areas with a high concentration of MARPs.

The HIV/AIDS program in Angola has undergone major development and expansion over the past several years; however, it has not developed a systematic basis to determine the characteristics of the pandemic. In line with government policy to decentralize decision-making to sub-national levels, provincial and national forums play important roles in implementing HIV/AIDS strategies and contribute to national and regional development planning. Since each province is unique, institutional capacities, needs, and progress in implementing HIV/AIDS strategies and the "Three Ones" principles differ considerably among them. Therefore, programmatic responses are tailored to local realities. This is particularly important in rural and remote districts of the country, which poses considerable challenges in scaling-up interventions.

The USG continues to support the improvement of health management in direct collaboration with the Provincial Health Directorates of 8 high prevalence provinces (Luanda, Cunene, Kuando Kubango, Huambo, Lunda Norte, Lunda Sul, Cabinda, and Uige). This support aims at improving service delivery through scaling-up training at PMTCT and VCT sites (new sites as well), targeting existing health care workers to improve quality, enhance leadership, management, planning, M&E, and health service supervision. The program is integrated with other USG supported programs such as family planning, malaria and TB activities.

HIV CT is an important component of comprehensive HIV prevention and is a key entry point into HIV/AIDS treatment and care services. The GRA recognizes the importance of increased CT services, strong national leadership, and encouraging the population to know its HIV status. The GRA demonstrated their commitment to CT by including it in the NSP and the new Partnership Framework.

Challenges/Accomplishments in 09

The national CT program is steadily growing in Angola with approximately 5% of the general population aged 15-49 being tested. The number of persons tested nearly doubled since 2007; however, services are still insufficient. In 2008, 438,054 individuals aged 15 years and older received HIV testing and counseling and know their status (INLS 2008). National program data demonstrated that 15% of public health facilities provided HIV testing and counseling services.

In FY 2009, the USG support for CT focused on supporting the national strategic plan by creating an enabling environment for effective counseling and testing, and developing linkages with other health services. To facilitate this support, USG partners worked with provincial health directorates in 8 high prevalence provinces to extend CT services in 38 selected health facilities. In addition, the USG continued to work to integrate CT activities with other services within government health facilities to guarantee sustainability. The INLS took the lead on CT and the USG provided support by:

•Training existing staff as counselors in the facilities;

•Rehabilitating, equipping, and furnishing facilities to adapt infrastructure for optimum counseling and testing activities;

•Collaborating with the INLS on the procurements and logistics of test kits and other supplies required for

counseling and testing;
•Providing technical assistance to the INLS to strengthen VCT management at the provincial level; and
•Encouraging and promoting task-shifting with inclusion of lay counselors especially in areas where medical service is limited.
The USG collaborated with the FAA to establish 6 clinics beginning in 2007, offering VCT services in Luanda, Huambo, Cabinda and Lubango. The purpose of increasing the number of VCT centers was to raise awareness and increase access for military populations, their families, and the catchment population to CT services. Data collected through VCT has improved data for decision making.
In FY09, the USG successfully provided TA to the INLS for updating policy and guidelines to strengthen strategic guidance for CT. Efforts continued to coordinate implementing partners at the provincial and district levels more effectively to address issues of logistics, linkages and referrals, training, staffing, and lessons learned as services were rolled out. In January 2009, an assessment of the EHSP was conducted and the conclusions were positive in relation to the VCT activities. In addition, the program continued providing technical assistance for a more focused advocacy approach for the use of GRA funds and the GFATM. In addition to continued activities, the USG:
•Promoted the best practice of lay counselors conducting CT to assist in activities both in the facility and home-based/outreach settings;
• Strenghtened supervision of rapid tests, utilization of a CT register, M&E for CT to ensure consistency across all partners, and other standards for provision of quality CT services (training and re-training for counselors and nurses, etc.);
•Promoted the best practice of incorporating people living with HIV/AIDS (PLWHAs) into prevention, CT, and care activities;
•Promoted the integration of Provider Initiated Counseling and Testing (PICT) into the hospital system; and
•Coordinated with water purification activities at VCT sites through the USG funded Certeza project aimed at diminishing water-born infections.
Goals and strategies for 2010
The FY 2010 COP strategies for CT are linked directly to the Partnership Framework and the Partnership Framework Implementation Plan goals, specifically, Goal 3: Mitigate the socioeconomic impact of HIV/AIDS on individuals, the family, and the community. During the first two years of the PFIP, HIV/AIDS activities, including CT will continue in the 8 provinces currently being supported by the USG and scaled up in two of the provinces, Luanda and Cunene, and the transport corridors between them.
In general, in FY 2010 support at the national, provincial and municipal levels will increase the number of new centers, preferably integrated with PMTCT, and also mobile clinics, particularly in the two priority provinces and along the transportation routes. The USG will continue to promote PICT at the facility levels (ANC, TB, STIs etc.) while encouraging Client Initiated Counseling and Testing (CICT) at the community level. Direct VCT services will be focused on MARPs and youth as well as the general population.
Through the PFIP, and funded by COP 2010, the USG will support training of health center staff in CT to improve the quality of counseling, outreach and follow-up services for those who test positive. In addition, significant efforts will be focused on strengthening the M&E system to capture CT data.
The USG, in collaboration with UNICEF, is supporting the MOH and INLS to progressively establish CT in all municipal health centers. Efforts are also being made to provide VCT opportunities through outreach mobile services to ensure that the majority of the population has access to basic services. Although the FAA coordinates on a regular basis with the Angolan institutions responsible for defining and coordinating efforts to fight HIV (i.e., GFATM Country Coordinating Mechanism (CCM), the INLS, and the MOH), it acts independently and with relative autonomy from these institutions. Mobile VCT and linkages to care and treatment will be targeted at hard-to-reach military personnel and surrounding communities. The FAA is concerned that many of their HIV-positive personnel come for medical assistance too late to receive the care needed to prolong and improve life. Under the Partnership Framework and COP, the USG will provide technical assistance for setting up a "positive living" program in the military in addition to support of psychologists, lay counselors, and physicians for those who test positive.
In FY 2010, the USG will specifically:

• Empower the provincial and municipal health systems and, NGOs/CBOs to engage in prevention efforts at the community level to strengthening the capacity of the health sector, military, and civil society to expand CT;
• Provide both technical assistance and financial support to strengthen and expand VCT to cover extended families of HIV positive persons, youth, MARPs, and others;
• Support expanded youth friendly health services, in partnership with the MOH and the provincial and municipal health services to expand VCT, STI and follow up referral for reproductive health services;
• Strengthen the capacity of healthcare workers in PMTCT, VCT and follow-up to ensure quality control of provided services.
• Strengthen the capacity of community health workers and NGOs through training, supervision and performance monitoring to scale up community-based VCT;
• Provide TA to the MOH for the development of a VCT policy and plan for task shifting from nurses to auxiliaries, and for establishing a policy for community health workers to provide follow up to diagnosis results (both positive and negative), care and support, and treatment (adherence);
• Formulate a strategy to reinforce the referral system and improve availability of test kits; and
• Implement the results of the PLACE study and other studies to strategically scale up VCT and condom distribution services.

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	3,050,000	
Total Technical Area Planned Funding:	**3,050,000**	**0**

Summary:
11. Health Systems Strengthening- Angola (OHSS) TAN
Context and Background
Angola is a post-conflict country recovering from a prolonged civil war, which ended in 2002. This devastating civil strife decimated the health infrastructure. Despite important GRA efforts and significant external assistance, Angola's health system still needs significant development as it does not provide adequate health care for the population. The country has 18 provinces. Most public resources are concentrated in the tertiary and secondary health care levels, leaving primary and rural health care centers with minimal support. Only 15% of the health work force provides services in rural areas, where over half of the population lives. The diversion of the nation's resources to fight the war and massive population dislocations led to sustained high levels of poverty, with 21% of the population now living in extreme poverty. This poverty, coupled with low access to health services, translates to poor health conditions, particularly for women.
Angola's population is an estimated 17 million with a HIV prevalence estimated at 2.1% among the population aged l5-49. Sixty-two percent of the population is under 24 years old. During 2004-2007, prevalence among young pregnant women rose from 2.7% to 3.1% (ANC 2005, 2007). Angola is bordered by the high-prevalence countries of Namibia and Zambia. Though Botswana does not border Angola directly, the two countries are separated only by a 30 kilometer stretch of uncontrolled land, which is concerning since the increased movement between the two populations could lead to increased transmission. A review of estimated HIV prevalence by province reveals significantly higher rates (estimated at 9.4%) in Cunene along the border with Namibia. Luanda and Cunene are two geographic areas with a high concentration of MARPs.
The HIV/AIDS program in Angola has undergone major development and expansion over the past several years; however, it has not developed a systematic basis to determine the characteristics of the pandemic. In line with government policy to decentralize decision-making to sub-national levels, provincial and

national forums play important roles in implementing HIV/AIDS strategies and recommendations, and contribute to national and regional development planning. Since each province is unique, institutional capacities, needs, and progress in implementing HIV/AIDS strategies and the “Three Ones” principles differ considerably among them. Therefore, programmatic responses are tailored to local realities. This is particularly important in rural and remote districts of the country, which poses considerable challenges in scaling-up interventions.

The USG continues to support the improvement of health management in direct collaboration with the Provincial Health Directorates of 8 high prevalence provinces (Luanda, Cunene, Kuando Kubango, Huambo, Lunda Norte, Lunda Sul, Cabinda, and Uige). This support aims at improving service delivery since 2006 through scaling-up training at PMTCT and VCT sites, targeting existing health care workers to improve quality, enhance leadership, management, planning, and health service supervision. The program is integrated with other USG- supported programs such as family planning, malaria and TB activities. Health Systems Strengthening, including building local capacity, is an essential component of the USG strategy in Angola.

Challenges/Accomplishments in 09

Angola continues to make positive strides, despite formidable challenges in recovering from 30 years of civil strife and transitioning from emergency health services to development. Containing and reducing the current relatively low-level prevalence of HIV/AIDS remain a national priority. However, achieving this objective is heavily dependant on improving the health service infrastructure. Developing this infrastructure is dependant on policy framework and management systems capable of delivering quality services in prevention, treatment and care in a sustainable manner. Accordingly, system strengthening is the MOH’s top priority. The current health system has a sizable staff of 64,000 health workers; however, their technical capacity is low. In addition, there are several policies that remain poorly defined and require revision, such as human resources for health, strategic information, logistics and drug management. The USG supports the WHO HSS single framework with six building blocks: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship).

In policy and system strengthening, the USG implemented the EHSP program and leveraged resources and created synergies with other USAID projects in decentralization and civil society strengthening. These synergies promote leadership roles for women and people living with HIV/AIDS (PLWHA). In addition, private sector enterprises, including multinational firms in the extractive industries, are additional sources for leveraging support for the GRA programs. Furthermore, the USG engaged the private sector in increasing their involvement in HIV/AIDS programs through the Angolan Business Alliance. This partnership of companies was led by the Brazilian construction company, Odebrecht, which, along with Coca-Cola and others, has a Global Development Alliance (GDA) agreement with USAID to leverage the firm’s experience and commitment to workforce HIV interventions and corporate social responsibility (condom distribution and testing in workplaces).

In FY 2009, the USG funded programs to support the DPS in the 8 PEPFAR-supported provinces to roll out in-service training, supervision, planning and managing HIV/AIDS, strengthening HMIS and stock management. More specifically, the USG supported service delivery training, updated clinical guidelines and SOPs, improved overall quality and capacity of health care workers, strengthened capacity of community health workers to promote PMTCT, and improved the ability of health facilities to improve coverage, control and adherence to clinical services. The USG plans to continue and expand the HSS support in COP 2010. Furthermore, with FY 09 Partnership Framework funds, the USG developed in collaboration with the GRA, the Angolan Field Epidemiology and Laboratory Training Program (FELTP) to respond to the need to improve workforce capacity in Angolan labs. FELTP is a public health training program designed to assist countries develop, set up, and implement public health strategies to improve and strengthen their public health system and infrastructure. The laboratory component of the program aims to strengthen the linkage between epidemiology and laboratory systems, primarily with the goal of using laboratory data to improve surveillance and outbreak response. An initial assessment was completed in July 2009.

In FY 2009, the USG maintained successful activities from FY 2007 and included the following activities

to support the continuity of services and improve the quality of programs by:
• Training in PMTCT and VCT procedures, quality service delivery, Lab technique, SI;
• Collaborating with the INLS and MOH on the standardization of national HIV policies, procedures and protocols. When policies and protocols were finalized, the USG supported the dissemination plan;
• Supporting the completion of the National Health Account (NHA) to better inform health sector planning and expenditure;
• Expanding support to the provincial level by assisting the Provincial Health Departments (DPS) in managing GFATM funding, strengthening the health management information systems (HMIS), data collection and use, forecasting, and stock management;
• Conducting an inventory of all available health services in the border region with Namibia. The EHSP (in collaboration with DPS in Cunene and Kuando Kubango) financed the exchange of experiences and lessons learned between health workers in Angola and Namibia;
• Continuing to support training and mentorship in organizational capacity building, specifically in management, finance and monitoring and evaluation;
• Active and constructive involvement through the GFATM CCM, where ministries and civil society are well represented; and
• Requesting TA from the USAID Regional Office for technical assistance in developing its HCD and M&E activities.
Goals and strategies for 2010
The FY 2010 COP strategies for HSS are linked directly to the Partnership Framework and the Partnership Framework Implementation Plan goals, specifically, Goal 1: Strengthening capacity for an effective national response to combat HIV/AIDS. During the first two years of the PFIP, HIV/AIDS activities, including HSS, will continue in the 8 provinces currently being supported by the USG and scaled up in two of those provinces, Luanda and Cunene, and the transport corridors between them. Luanda and Cunene have a high concentration of MARPs. Luanda is a continually growing, high density city, where over a quarter of the population resides; 60 % of the population is under 24 years old. Cunene is the primary border crossing with Namibia and is the province with the highest prevalence rate (ANC, 2007.) This focus will not divert PEPFAR efforts from other provinces; rather, it will serve to expand and implement lessons learned to improve the quality of much needed services.
In FY 2010 support will be provided through technical assistance and institutional capacity building to civil society partners for grant writing, management and supervision, leadership, financial management, and M&E. Further technical assistance will be provided to:
• Train health personnel for improved quality of PMTCT/VCT services, Lab and SI;
• Improve the functioning of the mobile clinics;
• Update national guidelines for CT policies;
• Strengthen the quality of counseling (including lay-counselors); and
• Strengthen M&E and supervision in the 8 provinces.

The shortage of qualified health care workers poses a major challenge for quality and sustainable health care delivery. Implementation of the Field Epidemiology and Laboratory Training Program (FELTP) will 1)enhance retention of health care providers through specialization opportunities; 2) increase the number of qualified professionally trained health care workers through short trainings (60 annually in field-based applied epidemiology, laboratory management and public health practice training); 3)strengthen the capacity of health and training institutions to meet accreditation standards; 4) contribute to the development of specific evidence-based pre-service curricula; 5) in collaboration with the Avian Influenza program, 6 residents to earn a specialization or masters degree in public health; 6) develop curriculum for training trainers and terms of reference for the lab trainers to build human resources to support expansion and decentralization of the laboratory network. Partnerships will be sought with the private sector to support students enrolled in the program. The program will be initiated in Luanda; other provincial universities that are now being established could receive training support initially via distant learning technology sponsored by the World Bank. Technical assistance will be provided to explore twinning opportunities with compatible universities to strengthen and adopt standardized, pre-service competency-

based education driven, by evidence of need. These initiatives will leverage efforts of the European Commission to support provincial and municipal health services in 6 provinces with training for doctors and nurses, 1000 community health workers.
In FY 2010, the USG will specifically:
• Support the MOH in developing the capacity of existing health care workers (doctors, nurses, nurse-midwives, medical assistants, laboratory technologists; pharmacy Technicians) by upgrading their clinical, leadership, management, planning, supervision skills via in-service training at the provincial and municipal levels;
Support the MOH in developing a policy and plan for task shifting to nurses and other healthcare professionals;
Expand quality control systems at municipal and provincial levels to strengthen supervision of health workers in the public health system and the community;
• Strengthen the existing continuing education and supervision of provincial and municipal master trainers;
• Strengthen community health worker capacity to promote PMTCT through training;
Provide technical assistance and training to develop a PMTCT expansion strategy including EID;
• Support the MOH in improving the information system used to track and manage the training needs and implementation of the public sector health work;
• Provide technical assistance in the areas of finance and planning, national health accounts, and gap analysis to the MOH;
• Support policy formulation, training and technical assistance in health units to offer MARP friendly services;
• Update pre-service training curricula in TB/HIV and continuing education curricula for HIV/STI, Reproductive Health and Family Planning, infectious diseases according to criteria, procedures and norms of WHO in high prevalence zones, and implement national norms for TB/HIV co-infection;
• Support MOH and INLS in conducting a HRH assessment that will lead to formulation of the Human Resources Strategic Plan and in developing a Human Resources Information System, beginning in priority zones;
• Leverage other USG funds and in collaboration with WHO, will conduct a health system assessment;
• Support retention of human resources in the reference laboratory;
• Provide technical assistance for the revision and extension of the National Strategic Plan (2010 - 2014);
• Develop a technical assistance plan for Angola FELTP program activities, including a career structure for trainees;
• Train administrators in military hospitals and coordinators of HIV units in management and planning;
• Train health professionals to support the positive living program in the military;
• Assess the potential of clinical mentoring between US Navy Medical Center in San Diego and FAA Health Division;
• Collaborate with PMI to improve the management of the Essential Drug Program, especially around procurement and logistics of ARV's, test kits and drugs for opportunistic infections, including TB drugs for DOTS;
• Provide technical assistance for managing projections, estimates and inventories of consumable goods and laboratory reagents;
• Evaluating existing laboratory structure in 9 provinces
• Developing a National Strategic Plan for Laboratory Network and Implementation plan
• Training of Laboratory technicians in diagnosis and quality systems,
• Conduct a gender based assessment with a strong focus on gender based violence; and
• Support twinning activities between an international university (TBD) and a public university in Angola.

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount

HLAB	460,000	
Total Technical Area Planned Funding:	**460,000**	**0**

Summary:
9. Laboratory (HLAB) TAN
Context and Background
Angola is a post-conflict country recovering from a prolonged civil war, which ended in 2002. This devastating civil strife decimated the health infrastructure. Despite important GRA efforts and significant external assistance, Angola's health system still needs significant development as it does not provide adequate health care for the population. The country has 18 provinces. Most public resources are concentrated in the tertiary and secondary health care levels, leaving primary and rural health care centers with minimal support. Only 15% of the health work force provides services in rural areas, where over half of the population lives. The diversion of the nation's resources to fight the war and massive population dislocations led to sustained high levels of poverty, with 21% of the population now living in extreme poverty. This poverty, coupled with low access to health services, translates to poor health conditions, particularly for women.
Angola's population is an estimated 17 million with a HIV prevalence of 2.1% among the population aged l5-49. During 2004-2007, prevalence among young pregnant women rose from 2.7% to 3.1%. Angola is bordered by the high-prevalence countries of Namibia and Zambia and the growing prevalence of the Democratic Republic of the Congo and the Republic of the Congo (Brazzaville). In addition, although Botswana does not border Angola directly, the two countries are separated by only a thirty kilometer stretch of uncontrolled land, which is concerning since to the increased interaction and movement between the two populations could lead to increased transmission. A review of estimated prevalence by province reveals significantly higher rates in Cunene along the border with Namibia, where the prevalence rate is estimated at 9.4%. The main mode of transmission is heterosexual sex which accounts for 80% of the HIV infection. Key drivers of the epidemic include 1) the common practice of multiple concurrent partnerships; 2) low and inconsistent condom use; 3) harmful gender and cultural norms; and 4) transactional and commercial sex work. In addition to transactional and commercial sex workers, mobile populations including truck drivers, miners, military personnel and the police are assumed to be among the most at risk populations.
The HIV/AIDS program in Angola has undergone major development and expansion over the past several years; however, it has not developed a systematic basis to determine the characteristics of the pandemic. In line with government policy to decentralize decision-making to sub-national levels, provincial and national forums play important roles in implementing HIV/AIDS strategies and recommendations, and contribute to national and regional development planning. Since each province is unique, institutional capacities, needs, and progress in implementing HIV/AIDS strategies and the "Three Ones" principles differ considerably among them. Therefore, programmatic responses are tailored to local realities. This is particularly important in rural and remote districts of the country, which poses considerable challenges in scaling-up interventions.

The USG continues to support the improvement of health management in direct collaboration with the Provincial Health Directorates of 8 high prevalence provinces (Luanda, Cunene, Kuando Kubango, Huambo, Lunda Norte, Lunda Sul, Cabinda, and Uige). This support aims at improving service delivery through scaling-up services, targeting existing health care workers to improve quality and enhance leadership, management, planning, and health service supervision. The program is integrated with other USG-supported programs such as family planning, malaria and TB activities.

Challenges/Accomplishments in FY09
Based on the 2009 INLS first quarter report, the number of VCT sites and coverage of PMTCT services

increased significantly since 2004. This expansion of VCT and PMTCT services corresponds to a significant increase in HIV testing. Due to logistical constraints and challenges regarding procurement of lab reagents and commodities, HIV diagnosis in the Angolan public health system is predominantly via rapid testing. Major bottlenecks have been faced in the implementation of HIV follow-up and care due to inadequate laboratory capacity (e.g. inability to measure CD4 counts, viral loads, and/or conduct TB microscopy).
The PEPFAR funded USG programmatic laboratory support in Angola was embryonic in the past years. Technical assistance on HIV diagnostic techniques have been provided in the past. In FY09, activities related to malaria (PMI) and Influenza (AI CDC-MoH Cooperative Agreement) diagnosis have been supported in a more vertical system. This has contributed to a better understanding of the strengths and limitations of the overall laboratory structure and capacity in Angola.
In FY 2009, the USG in partnership with the INSP and INLS and other partners established an EID pilot project in conjunction with the laboratories. The support covered a laboratory assessment, and on-the-job training for the implementation of PCR technology for EID at the reference lab, and enrollment on both EQA and PT CDC programs for testing. Identified PMTCT sites were provided with on-the-job training in DBS sample collection, storage, and transport. The USG leveraged the Clinton Foundation to provide support for sample collection bundles and test kits and reagents.

In FY 2009 the USG TA provided to lab personnel included the following:
• Training of reference lab technicians on Molecular Biology Principles for Sequencing and Genotyping HIV-1 for Drug Resistance Studies as base for the ARV resistance study using the ANC 2009 samples;
• On-the-job trainings on ELISA techniques and underlying immunological concepts at the reference lab;
• Training of Provincial Laboratory Trainers on DBS sample collection, storage and transportation, HIV rapid testing diagnosis according to national algorithm and syphilis diagnosis in preparation for the ANC 2009 Seroprevalence Study; and
• Training on molecular biology techniques for Influenza virus diagnostic and characterization, and on lab procurement and logistic requirements for the successful implementation of the diagnostic capacities in country (AI agreement).

A solid laboratory network based on quality training and supervision is now essential to support expansion and decentralization of HIV services. A tiered national laboratory infrastructure, structured over a national strategic plan, must be strengthened to optimize quality systems and support the sustainability of the response to HIV/AIDS. In FY09, efforts were made by the Angolan MOH to support conditions to establish a functional National Reference Laboratory within the National Institute of Public Health (INSP) with USG assistance.

Goals and strategies for 2010
The FY 2010 COP strategies for CT are linked directly to the Partnership Framework and the Partnership Framework Implementation Plan goals, specifically, Goal 1: Strengthening capacity for an effective national response to combat HIV/AIDS.

A well structured laboratory network is essential to support expansion and decentralization of HIV services. In collaboration with the MOH, a well structured and effective laboratory network strategy will be developed that aims to ensure appropriate national policies on laboratory practices and quality assurance measures. With appropriate policies on laboratory practices and effective quality systems in place, USG will be better equipped to support the sustainability of the response to HIV/AIDS in Angola. A comprehensive lab assessment will be conducted to existing laboratory structures in health facilities at central and provincial levels. This will support the design of a laboratory network national strategic plan and a corresponding implementation plan that maximizes existing capacities including human resource. This activity will guide the MoH and its partners in directing and coordinating efforts aimed at laboratory accreditation. USG will also provide TA on the creation of a national advisory and technical committee, involving both laboratorians and clinicians. In addition, close collaboration with the Provincial

Governments and the Provincial Health Directorates is the key for the implementation of a sustainable national lab network. A provincial focal point for the laboratory network will be appointed to facilitate MoH efforts and to contribute to specific issues at large.

Quality systems are the basis for an appropriate laboratory performance and network, from management to supply chain management systems, from human resources to the sample traceability or implementation of external quality assurance programs for testing – including sample re-testing at reference lab and testing of proficiency panels at sites. This is essential for all HIV programmatic areas (VCT, PMTCT, EID), patient follow-up, adherence, systematic disease surveillance, and monitoring and evaluation. In FY 10, an assessment of the existing laboratory structure, its capacity, operational status, and main constraints from the municipal to the national level will be conducted.
To support the implementation of quality systems, USG will support the incorporation of a quality manager at the reference laboratory (INSP) and its enrolment in a quality mentoring program. Quality manager will develop, within the scope of the mentoring program, a quality plan for the reference laboratory towards accreditation and coordinate the implementation of the plan. Quality manager will be a key element on supporting quality systems, developing and implementing a quality assurance plan for national laboratory network. These are subsequent activities that USG plans to support in years following 2010.
Supply Chain Management Systems is a key component for laboratory and laboratory network functionality. It should be planned and coordinated for national level to maximize efforts and funds and to harmonize procedures and supplies. In the specific context of Angola, SCMS is a major challenge to implement laboratory activities. In FY2010, USG will support a detailed comprehensive assessment of the current status of the Angolan MoH SCMS.
Also as a major area for quality systems, laboratory information systems are essential to support public health laboratories. Angola still has a very weak paper based LIS and collection information is a challenge. In FY10, USG will support an assessment, of the current situation and major gaps, and posterior planning for a harmonized nationwide laboratory information system.
Extensive specialized “on-the-job” training is required for the different laboratory techniques throughout the country, including for all quality system components at the laboratory. In-service hands-on trainings directed to laboratories at provincial level will be supported. Technicians successfully completing training will act as trainers at the municipal level. For technicians at the central level, USG will support attendance at international hands-on trainings and scientific conferences.
USG will support manufacturer/service provider maintenance service contracts for both biosafety equipment and molecular biology equipment at the reference laboratory. USG will advocate for a sustainability plan to include training opportunities for engineering technicians.
Implementation of the Field Epidemiology and Laboratory Training Program (FELTP) will also be supported through curriculum development for training of trainers and terms of reference for the lab trainers to build human resources to support expansion and decentralization of the laboratory network.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	4,885,000	
Total Technical Area Planned Funding:	**4,885,000**	**0**

Summary:
(No data provided.)

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	700,000	
Total Technical Area Planned Funding:	**700,000**	**0**

Summary:
Context and Background
Angola is a post-conflict country recovering from a prolonged civil war which ended in 2002. This devastating civil strife decimated the health infrastructure. The country has 18 provinces. Most public resources are concentrated in the tertiary and secondary health care levels, leaving primary and rural health care centers with minimal support. Only 15% of the health work force provides services in rural areas, where over half of the population lives. Twenty-one % of the population is living in extreme poverty with limited access to health services. This translates to poor health conditions for this population, particularly for women.
Angola's population is an estimated 17 million with a HIV prevalence estimated at 2.1% among the population aged l5-49. Sixty-two percent of the population is under 24 years old. During 2004-2007, prevalence among young pregnant women rose from 2.7% to 3.1% (ANC 2005, 2007). Angola is bordered by the high-prevalence countries of Namibia and Zambia. Though Botswana does not border Angola directly, the two countries are separated only by a 30 kilometer stretch of uncontrolled land, which is concerning since the increased movement between the two populations could lead to increased transmission. A review of estimated HIV prevalence by province reveals significantly higher rates, estimated at 9.4 %, in Cunene along the border with Namibia. Luanda and Cunene are two geographic areas with a high concentration of MARPs.
The HIV/AIDS program has undergone major development and expansion over the past several years since the start of the national HIV/AIDS program. However, it has not developed a systematic basis to determine the characteristics of the pandemic. In line with government policy to decentralize decision-making to sub-national levels, provincial and national forums play important roles in implementing HIV/AIDS. Programmatic responses are tailored to local realities as a result of the decentralization and pose considerable challenges in scaling-up interventions in rural and remote districts.
The USG continues to support the improvement of health management in direct collaboration with the Provincial Health Directorates of 8 high prevalence provinces (Luanda, Cunene, Kuando Kubango, Huambo, Lunda Norte, Lunda Sul, Cabinda, and Uige). This support aims at improving service delivery by scaling-up training at PMTCT and VCT sites and other health systems strengthening issues.
The Reproductive Health (RH) and Maternal and Child Health (MCH) multi-agency group (USAID/WHO/UNICEF/UNFPA), lead by the MOH, conducted a baseline assessment in 2006 and an Emergency Obstetric and Neonatal Needs Assessment. Three national policy documents were approved by the MOH based on the assessments: 1) National Roadmap to Accelerate Maternal and Newborn Health (2006-2010); 2) Strategic Plan to Reduce Maternal and Child Mortality (2004-2008); and 3) Strategic Plan to Guarantee RH Commodity Security (2008-2012). Guidelines for implementation of these plans are in effect in the provinces under the leadership of the National Directorate of Public Health.
Challenges/Accomplishments in 09
PMTCT is a priority in the Angola National AIDS Strategic plan (2007 – 2010). Specific targets are to increase access to PMTCT services to reach all pregnant women in Angola by the end of 2010. Realistically, this target will not be met as prenatal care coverage remains low with only 45% of pregnant women having assisted deliveries by health personnel. In addition, an estimated 90% of pregnant women living with HIV do not receive antiretroviral therapy for PMTCT (UNAIDS 2008). Furthermore, gender disparities and fear of violence leave women and girls with limited capacity to access services and disclose status if tested. However, in 2009, Provider-Initiated Counseling and Testing (PICT) and other strategies were adopted to strengthen PMTCT through primarily HIV prevention, ARV prophylaxis, as well as improvements in the physical infrastructure for delivery and training for health care workers. These

improvements, coupled with coherent communication strategies resulted in creating an increased demand for PMTCT services. To date, there around 1100 health facilities with ANC services, of which 220 are health centers with integrated PMTCT throughout the ANC services and maternities. The USG support approximately 25% of theses PMTCT sites.
The Instituto Nacional de Luta contra o SIDA (INLS), under the MOH, was mandated to coordinate the national HIV/AIDS response. This includes implementing the majority of PMTCT activities, despite extremely limited qualified health care providers. The INLS understands that the integration of health services reduces the burden on scarce human resources, and therefore requested USG technical assistance (TA) in 2009 to help improve and scale up the integration of PMTCT services into RH, MCH, family planning, and malaria services. With the support of the USG and other partners, the INLS developed a set of new PMTCT policy and PMTCT guidelines in 2008. Finally, the USG piloted with the Provincial Health Department (DPS) the utilization of nurses to provide PMTCT services under the supervision of medical doctors to increase coverage and availability of quality services.
In accordance with the INLS's goal to scale up PMTCT services in health facilities with antenatal care, labor and delivery, the USG Essential Health Services Program (EHSP) provided TA to establish new PMTCT services in 37 health centers selected by the provincial governments, taking into account the availability of trained human resources. The USG funded EHSP project works in collaboration with the GFATM and UNICEF to provide TA and financial support to the national PMTCT program in 8 provinces with high prevalence rates. The EHSP collaborates with civil society organizations (CSOs) which play a vital policy and advocacy role in ensuring that PMTCT services are available to all HIV-positive pregnant women, including follow-up of adherence of prophylaxis. In addition, the EHSP works with the NGO ANASO (a network of HIV NGOs) and RNP+ (a network of people living with HIV also financed by USG) to improve the follow-up services of women after they leave the facilities. This program, in collaboration with DOD, will encourage partners to be tested and participate in the health care of the family and strengthen waiting houses. This USG-supported waiting house pilot is designed for HIV+ pregnant women living in remote places to remain closer to health facilities in the days before delivery to ensure access to services. It also provides post delivery housing for follow up care needed for women and their children free of charge and has greatly increase women's ability to access services.
The GFATM supports the procurement and distribution of ARV drugs for PMTCT and VCT programs in the maternity wards, hospitals and prenatal health services, and UNICEF is piloting PMTCT interventions in provincial hospitals. Working in collaborating with GFATM, USG implementing partners are working closely with facilities to improve the supply chain management of these commodities Furthermore, PEPFAR strengthened collaboration with the Presidential Malaria Initiative (PMI) nationally and in provinces where the initiatives overlap at ANC sites. Women who were identified as HIV+ received a bed net and women who were diagnosed with malaria were provided treatment along with HIV prevention messages. PMI programs provided recommended doses of IPT in HIV+ pregnant women. Malaria training for health care workers included a component on HIV prevention and strategic information data collection. As long as adequate funding and drug supplies are available PEPFAR and PMI will continue to work with the INLS to promote this integration of services and improved management of drug supplies and warehousing.
In 2009, the USG provided support by:
• Providing TA on policy implementation, training, rehabilitation and advocacy for the uptake of services in order to improve the provision of PMTCT services. This approach focused on ensuring that systems were in place to increase the number of women and their partners with access to services and to promote adherence;
• Conducting protocol and curricula training for new government PMTCT staff to meet national and international standards;
• Collaborating with UN agencies, to support the INLS in the implementation and training of protocols and guidelines for breastfeeding and EID;
• Providing support for the task shifting;
• Providing training to medical doctors, nurses, auxiliary nurses, midwives, laboratory technicians and pharmacists to improve the quality of services and encourage task-shifting;

• Ensuring that PMTCT services are carried out in an appropriate environment, where privacy, dignity and bio-safety measures were guaranteed and observed; and
• Minimal, but necessary, rehabilitation improvements for antenatal consultations and labor and delivery. The rehabilitation work included partitioning, painting, replacing windows and doors, etc.
• Strengthening adherence to ANC, PMTCT and ARV prophylaxis through a local NGO.
• Establishing waiting houses for pregnant women at risk and facilitating compliance with prophylaxis during delivery.

Goals and strategies for 2010
The FY 2010 COP strategies for PMTCT are linked directly to the Partnership Framework (PF) and the Partnership Framework Implementation Plan (PFIP) goals, specifically, Goal 2: Reduce the spread of the HIV epidemic and Goal 3: Mitigate the socioeconomic impact of HIV/AIDS on individuals, the family, and the community. During the first two years of the PFIP, a PMTCT assessment will be planned and conducted to inform the process for scaling up PMTCT.HIV/AIDS activities, including PMTCT will continue at their existing levels in all 8 provinces currently being supported by the USG and scaled up in two of the priority provinces with a high concentration of MARPs- Luanda and Cunene and the transport corridor between them. The focus on Luanda and Cunene will serve to expand and improve the quality of much needed services.
During PEPFAR I, approximately 300 master trainers in 30 municipalities in the eight high prevalence provinces were trained in Integrated Health Services; and more than 100 were certified to provide ongoing continuing education and supervision for both health care workers and community health workers. In FY 2010, TA will be provided to train and certify additional master trainers who work within the DPS's (provincial health directorates) to provide supervision and ongoing continuing education for provincial and community health workers. This support aims to improve the quality of integrated (MCH/ANC/Malaria/FP/PMTCT) service delivery and strengthen human resource leadership and management skills to scale up PMTCT and VCT at the municipal level. With this infrastructure already in place, in–service training for doctors, nurses, nurse-midwives, and medical assistants, established in the 30 municipalities during PEPFAR I will be expanded to new municipalities in the eight selected provinces after the initial scale up in the two priority provinces. In addition, the existing continuing education and supervision of provincial and municipal master trainers will be strengthened and expanded.
FY10 support will be provided at the national, provincial and municipal levels to increase the number of new health centers with PMTCT services. Under the PFIP, the PMTCT focus will be on significantly increasing the number of pregnant women tested and counseled (at least 80% over five years) and increasing the number of children born to positive mothers with negative status. In addition, an emphasis will be placed on the expansion of family planning use among women after delivery. The main objective of the PMTCT strategy is to reduce vertical transmission of HIV by providing support to the MOH, provincial and municipal authorities. Early Infant Diagnosis (EID) implementation will be integrated within the PMTCT services to measure the impact of PMTCT activities. An external evaluation of the PMTCT package will serve as the input for scaling-up PMTCT/EID services, including VCT at ANC and prophylaxis during delivery and post partum, for strengthening integration linkages with MCH/FP Services, including the promotion of male involvement as partners. The data provided by the evaluation will be essential for designing programs that improve services for clients, increase capacity of health care and community workers, and CSOs to deliver PMTCT services and effectively reach out to the community and maximize impact.
Data will be routinely collected through service statistics and from a monitoring system designed to continuously track programmatic progress. Key evaluation data to measure program impact will also be collected by replicating the ANC HIV sero-prevalence surveys of 2004, 2005 and 2007. The expansion of sentinel sites will provide continuous data in the future, thus reducing the need for sero-prevalence surveys for ANC.
In FY 2010, the USG will focus specifically on the following activities:
• Scaling-up PMTCT coverage to 66 sites in 8 provinces with the highest HIV prevalence (Luanda, Huambo, Lunda Norte, Lunda Sul, Cabinda, Kuando Kubango, Cunene, Uige), including the transport

route between Luanda and Cunene;
• Opening new PMTCT sites by rehabilitating existing ANC centers in collaboration with the GRA; USG and GFATM funding to integrate services at government health facilities;
• Conducting an internal evaluation of the USG PMTCT package;
• Increasing CT coverage in prenatal services, and CT and PMTCT at delivery and post partum at the provincial and municipal levels;
• Increase provision of RH/family planning services at PMTCT sites;
• Scaling-up USG supported PMTCT services to 60,000 pregnant women in the country;
• Training 176 health workers to provide PMTCT services according to the new protocols;
• Expanding the EID activities, including follow-up until 18 months at all USG supported PMTCT-sites;
• Promoteing adherence and prophylaxis for positives policy at the site level;
• Conducting an ANC Sentinel Surveillance study every 2 years until a passive surveillance system is successfully implemented.

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVAB	1,825,000	
HVOP	3,675,000	
Total Technical Area Planned Funding:	**5,500,000**	**0**

Summary:
Sexual Prevention TAN
Context and Background
Angola's population is an estimated 17 million with a HIV prevalence estimated at 2.1% among the population aged l5-49. Sixty-two percent of the population is under 24 years old. During 2004-2007, prevalence among young pregnant women rose from 2.7% to 3.1% (ANC 2005, 2007). Angola is bordered by the high-prevalence countries of Namibia and Zambia. Though Botswana does not border Angola directly, the two countries are separated only by a 30 kilometer stretch of uncontrolled land, which is concerning since the increased movement between the two populations could lead to increased transmission. A review of estimated HIV prevalence by province reveals significantly higher rates, estimated at 9.4%, in Cunene along the border with Namibia. Luanda and Cunene are two geographic areas with a high concentration of MARPs.
PEPFAR Angola's COP 2010 sexual prevention B21 represents a strengthened and continued focus on quality state-of-the-art programming, in line with what is known about Angola's epidemiological profile.Main mode of transmission is heterosexual sex (80%). Key drivers of the epidemic include 1) multiple concurrent partnerships; 2) low level of consistent and correct condom use; 3) harmful cultural and gender norms that oput both men and women at risk; 4) transactional and commercial sex; 5) general low level of knowledge and risk perception. While limited data exists in Angola, there is evidence of certain populations with apparent high vulnerability and risk. These include:
Youth
The 2005 Tracking Results Continuously (TRaC) study conducted by PSI with USG support shows that the mean age of sexual debut is relatively young (15 years). An estimated 77% of young people aged l5-24 in the general population did not correctly identify ways of preventing sexual transmission of HIV, and up to 32% of youth initiated intercourse before the age of 15 (UNAIDS, 2008). According to the UNGASS/Angola report (2008), an estimated 66.8% of the population aged 15-24 does not use condoms with their non-regular partners, and only 5.9% in that same age group were ever tested for HIV.
Commercial Sex Workers (CSWs)

Evidence from 2006 INLS data indicates that HIV prevalence rates in CSWs in Luanda is 23.1% and 16% for CSWs overall in Angola. There are an estimated 4,000 CSWs in Luanda and 800 in Cunene. Women working in commercial sex in Cunene do not self identify as CSWs, while those in Luanda are more likely to self identify and work in brothels and are street-based. Of these populations in Luanda, 86.6% reported always using a condom in the last 30 days and 59% reported ever having had an HIV test (both represent increases from 2005 data). In Cunene only 25.4% of CSWs reported using a condom in the past 30 days and 59.6% reported having had an HIV test in the past 12 months, a modest increases from 2005 (TRaC studies 2005, 2008).

Truckers

The TRaC study in 2008 showed that 27.9% of truckers reported always using a condom in the last 30 days and 35.3% reported that they had none or only had 1 partner in the last 30 days. In 2008, 32.3% of truckers reported having had an HIV test (a slight increase from 2005 data).

Military

IN 2003/04, Drew University conducted a BSS on military personnel in four regions of Angola. Of the respondents, 60% reported having had two or more sexual partners during the last year. HIV prevalence in the military at that time was estimated to be 3.6%. The results also showed higher prevalence in the capital and cities along the border and very low rates in the center of the country where people have remained fairly isolated. Risk perception was generally low and a high number of respondents did use condoms at the time of their sexual encounters when they had access to them.

General Adult Population

More than half of VCT clients reported not using a condom in the last three months, 35% reported sometimes using a condom, and 7% reported always using a condom. Reported condom usage at last sex was 20%, condom use with a regular partner was slightly lower at 15%, while use with a casual partner (among those who reported having a casual partner) was 30%. Of males tested for HIV at VCT sites, 28% reported having concurrent partnerships. (TRaC) From these TRaC studies and anecdotal evidence it appears the practice of multiple concurrent partnerships and support for several households is common in Angola among the general population.

Anecdotal data indicate that the majority of the population knows where condoms are available; so the lack of availability is not a contributing factor to low level of condom use in Angola. Free condoms are available to the general population in VCT and ANC clinics financed by INLS. Female condoms are available mainly at ANC clinics. PEPFAR Angola distributes free generic condoms to implementing partners, mainly through the health system strengthening and BCC activities. In FY2010, the goal is to extend the distribution of generic condoms to the military through our implementing partner, Charles Drew University.

Levels of male circumcision (MC) in Angola are not well documented or known; however anecdotal evidence suggests that Angolan men in general are circumcised. Additional, it suggests that levels of MC are lower in the two southern provinces of Cunene and Kuando Kubango, the two provinces with the highest prevalence of HIV in Angola.

Challenges/Accomplishments in 09

The USG, working together with other stakeholders, is making strides in HIV/AIDS prevention and capacity building of local NGOs in prevention. The USG's strategic approach to prevention targets geographically in high prevalence provinces and the general, most-at-risk and other vulnerable populations--with an emphasis on in- and out-of-school youth, military personnel, truck drivers and CSWs and their clients.

Specific FY 2009 activities included:

• Jango Juvenil youth centers promoted HIV/AIDS prevention and life skills through age appropriate messages targeting in- and out-of-school youth aged 15-24;

• Youth peer educators managed by local partner NGOs conducted interpersonal communication (IPC) and BCC activities among young people aged 15-24;

• NGO's implemented BCC and IEC interventions targeting CSWs and truckers. Additional, in-depth studies were conducted with CSWs to learn more about behavior and appropriate programming;

• NGOs conducted social marketing campaign supporting the INLS national strategic plan to combat STIs

including HIV. The campaign focused on communication interventions in at-risk provinces, border areas, ports, major urban centers and along transport routes;
• Collaboration with the Angolan military in the production of IEC materials, and related prevention activities. These interventions included ABC messaging and BCC through mass media and peer education, management of STIs, and programs that encourage healthy behaviors, such as partner reduction.
• Outreach and training of educators included gender-equity messages and behaviors, and provided guidance on addressing social norms around violence and transactional sex.
• Capacity building of civil society organizations working with youth, CSW, and truckers in financial management, proposal writing, M&E, and fund raising.
Goals and strategies for COP 10
Building on the COP FY 2009, the Partnership Framework, and Partnership Framework Implementation Plan, the USG prevention strategy aims to create a supportive environment, with appropriate policies, laws and services, and engage government institutions and civil society organizations with the capability to carry out evidence-based programming while creating a greater understanding of the epidemic and behaviours that cause risk. The generation of new knowledge about transmission among specific sub groups will enrich the USG's prevention strategy and program, which will help inform the development of a National Prevention Strategy.
In late FY 2009, USG created a PEPFAR-wide Comprehensive Prevention Strategy to define the strategic focus of the portfolio. The goals of the strategy are to:
• Reduce risk behaviors: early sexual debut, multiple concurrent partners (MCP), transactional, trans-generational and commercial sex, inconsistent condom use, gender-based violence (GBV) and sexual risk associated with alcohol use.
• Reach vulnerable and high risk groups: in and out-of-school youth and adults, particularly those engaged with multiple concurrent partners (including polygamy), mobile men with money (e.g. truckers, military and police), and areas of high concentration of sex workers, with gender –sensitive approaches and;
• Target geographic areas/hotspot venues with high prevalence rates: areas of population density such as Luanda, border areas such as Cunene, and transportation corridors between Cunene and Luanda
Key components of the prevention strategy activities include making all interventions gender sensitive, as well as locally and culturally contextualized. BCC messages need to be based on understanding male and female norms about HIV prevention and reducing risk behaviors. In FY 10 focus will be to develop evidence based behavior change approaches, focusing on; epidemiological, behavioral and cultural data to understand behavioral patterns of target groups by age, sex and sub-culture; addressing gender relations; including reducing vulnerability of women and girls, male norms and increasing male participation.
Additional populations of concern and consideration for future targeting include miners, uniformed services (beyond the military), MSM, and prisoners. Programming for these populations will depend on data that becomes available within the next year.
In FY 2010, a number of studies will be conducted and will provide an increased evidence base for future strategic programming. Behavioral Surveillance Surveys (BSSs) will provide baseline data for behaviors of high risk groups; young women engaged in transactional sex, MSM, truckers, and military. Rapid assessments will be driven by other data such as the ANC HIV surveillance, Priorities for Local AIDS Control Efforts (PLACE) studies and AIDS indicator survey (AIS), implemented by the GRA and other partners. PLACE studies will be conducted to map hot spots of HIV risk for the general population. A GIS mapping exercise will provide a better understanding of where and what HIV services are provided in Angola.
The AIS, funded by GFATM, will include a question on prevalence of male circumcision in order to ascertain levels of MC in Angola. Based on the results from the AIS the USG will conduct a qualitative study of MC and cultural factors (e.g the social and cultural implications, the settings in which MC is conducted, perceptions of MC).
As data continue to emerge through these studies, the USG will focus programming on the known

vulnerable and most-at-risk populations and provinces. For each of the specific population of focus a distinct prevention package is needed. Each package will contain the essential components of condom promotion, and distribution, tailored messages on prevention, promotion of HIV voluntary counseling and testing services, STI prevention and treatment, stigma reduction for people living with HIV/AIDS, gender equity, and reduction of gender-based violence tailored for the specific populations. Messages and interventions will be delivered through a variety of channels including; mass media, community and group level (e.g. churches, community groups, etc.) and individual level through IPC and peer education. Efforts to address cultural and gender norms as well as alcohol use/abuse and risk of HIV transmission are cross-cutting themes that will be addressed in programming.
Specific areas of focus for FY 2010 activities will include:
• Youth prevention that will target boys and girls, in and out of school, and high risk youth such as street children, with specific activities and tailored messages to address behaviors, and cultural practices that put young men and women at risk of HIV infection. Activities for youth will promote abstinence, including the delay of sexual activity or secondary abstinence, fidelity, reduction of multiple and concurrent partners, condom promotion and distribution and related social norms that impact these behaviors. All youth activities will be age and locality appropriate.
• A reinforced approach to MARPs requires an improved understanding of their risk dynamics and best options for interventions. The AIS and BSS studies will provide this profile, permitting the scale- up and targeting of health, education and community facilities to better meet the needs of MARP sub-groups. VCT, and STI/HIV prevention sites will be expanded at points accessible to, and MARPS friendly, condom programming, distribution and social marketing that emphasizes consistent and correct use of condoms. Peer education will be expanded to reach street youth and commercial sex workers, and will include linkages to services for STIs, VCT, condom use., .
• Work with the military will be expanded and strengthened to reach additional uniformed personnel. Key components of the work with the military include: technical assistance for psycho-social support in the military, and training military psychologists and counselors for prevention with positives, with an emphasis on follow-up for treatment.
• The main objectives of the prevention package for the general population are to achieve the general level of knowledge and risk perception, adoption of a safer behavior, scale - up HIV prevention and health promotion, and expand health services, including condom programming and BCC/IEC messages, and scale up VCT, STI, and reproductive health services referral at provincial and municipal levels and in communities surrounding military bases. Activities for the general population will promote adoption of safer behavior, condom promotion and distribution and related social and community norms, Efforts to reduce alcohol use/abuse in the general population will be undertaken, as this is a known factor related to gender - based violence and forced and/or unprotected sex.
• The USG's partnership with the INLS, UNDP and the Brazilian corporate partner, Odebrecht through the Angolan Business Alliance (CEC), sets favorable conditions for the distribution of USG purchased condoms. Together with PMI and INLS, TA will be provided for effective logistics management and warehousing as a complement to the public sector distribution system. Additionally, the USG will continue utilizing the Central Contraceptive Procurement mechanism for free condoms to be used by implementing partners in prevention and may include supplying other partners (i.e. INLS, FAA, CEC).

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	1,605,000	
Total Technical Area Planned Funding:	**1,605,000**	**0**

Summary:

Strategic Information TAN
Context and Background
Angola's population is an estimated 17 million with a HIV prevalence estimated at 2.1% among the population aged l5-49. Sixty-two percent of the population is under 24 years old. During 2004-2007, prevalence among young pregnant women rose from 2.7% to 3.1% (ANC 2005, 2007). Angola is bordered by the high-prevalence countries of Namibia and Zambia. Though Botswana does not border Angola directly, the two countries are separated only by a 30 kilometer stretch of uncontrolled land, which is concerning since the increased movement between the two populations could lead to increased transmission. A review of estimated HIV prevalence by province reveals significantly higher rates in Cunene along the border with Namibia (9.4%). Luanda and Cunene are two geographic areas with a high concentration of MARPs.
National level HIV related data in Angola is limited to surveillance in pregnant women and a select number of Voluntary Counseling and Testing (VCT) sites. The 2004, 2005 and 2007 national HIV (hepatitis B and syphilis) antenatal clinic (ANC) surveys, with the last survey led by INLS via direct support from USG, are the only estimates of HIV prevalence. Currently, there are 36 ANC sentinel surveillance sites and 53 VCT sites. The INLS's ability to perform program monitoring and evaluation (M&E) and inform critical indicators relies on a technical working group comprised of consultants from various stakeholders, including USG and members of the INLS. Although no systematic process for M&E, routine surveillance, or standardized Health Management Information System (HMIS) exists, the GRA and the INLS continue to recognize the need for high quality data and technical assistance to support for program development and policy implementation. The new USG M&E program officer is tasked with liaising with local government and other stakeholders to facilitate the generation of better quality INLS routine data and the fulfillment of PEPFAR reporting requirements, as well as coordinating efforts across donors so that the national M&E program conforms to the UNAIDS "Three One's" principle.
Although data on sexual practices and behaviors among MARPs and other vulnerable populations are limited, results from three separate research studies conducted among young women, men who have sex with men (MSM), and truck drivers in 2008 revealed that: a) Engagement in transactional and/or commercial sex among young women on the Angola-Namibia border and those from other Angolan or Namibian provinces is common. This behavior gives rise to the establishment of sexual networks with the mobile population of generally older men, who come from different provinces and Southern African countries with high HIV prevalence rates. Transactional or commercial sex could be responsible for the relatively high HIV prevalence among young women in Cunene Province, 9.4%, the highest among young women aged 15 to 24 years in the 18 provinces of Angola; b) Strong social stigma against homosexuality exists in Luanda and throughout the country. Sexual "bridging" from bisexual men to women may account for a substantial proportion of ongoing heterosexual transmission. All MSM interviewed during formative research self-identified as heterosexual men with the majority reporting being married and having occasional sex partners in the past 12 months; and c) Sexual network of truck drivers interviewed in Luanda and along the transportation corridors between Cunene and Luanda appears to be quite dense. Many truck drivers reported at least two regular sex partners and occasional commercial and/or casual sex partners while waiting at the loading docks. This factor, coupled with high alcohol intake and low condom use, has potential to increase HIV/AIDS transmission in these areas.
The USG SI strategy is linked directly to the GRA National Strategic Plan (NSP), the Partnership Framework (PF) and the Partnership Framework Implementation Plan (PFIP) goals, specifically, Goal 1: Strengthening capacity for an effective national response to combat HIV/AIDS.
Challenges/Accomplishments in 09
Angola continues to face particular challenges regarding HIV SI, namely the lack of trained personnel to implement SI initiatives; however, despite these limitations in FY09, the USG was able to accomplish the following activities:
• Technical support for the 2009 ANC survey in which the INLS took the lead. Sample collection is near completion and preliminary data analysis results should be available in early 2010;
• Support INLS with data management and maintaining an Epi Info database for program data from VCT sites for a limited number of sites;

• Support population based behavioral surveys (BSS); planning and preparation for the BSS on young women started in April FY09 and data collection will start in Feb 2010.
• Collaboration with GFATM, WHO, UNICEF, UNAIDS and HAMSET providing technical assistance in the harmonization and standardization of M&E policies and indicators for prevention, diagnosis, care and treatment of HIV disease;
• Support the management of information systems at the provincial and municipal level where Essential Health Services Program (EHSP) provided training for health workers to increase the quality of the information system, analysis of data and its use for decision making.
• Implementation of a Tracking Results Continuously (TraC) monitoring tool for youth (ages 15-24) behavior is in the implementation phase and will provide valuable information for informing the effectiveness of various interventions for this important age group.
• Training to 225 health care workers at the provincial level in financial program management, program administration, strategic planning, and M&E for HIV/AIDS, TB, and Malaria.
• Support for an initial rapid assessment to identify geographic areas where HIV transmission is likely to be high among youth (ages 15-24) and where prevention programs could be focused. Priorities for Local AIDS Control Efforts (PLACE) study protocols were developed and they are pending final approval from the National Ethics Committee.

Goals and strategies for COP 10
During the PFIP process, the INLS specifically addressed the need for a) alignment and harmonization of PEPFAR indicators with the GRA; b) mapping of all current and future behavior and epidemiological studies; and c) defining the next steps regarding monitoring and evaluation efforts. By filling gaps in strategic information and promoting continued capacity, USG should strengthen GRA's increased ownership of the HIV/AIDS program and result in a declining need for USG assistance in SI over time. During PEPFAR I, the USG SI approach included activities presented in isolation rather than in relation to each other. The lack of an overall integrative approach resulted in missed opportunities to build on the successes of past activities. During PEPFAR II, USG will adopt a comprehensive and systematic SI strategy that is based on lessons learned from previous experiences. This overarching SI strategy will build local capacity to increase country ownership and provide data for decision making through a) surveys to assess local knowledge and perceptions about HIV/AIDS in the general population and vulnerable populations; b) evaluations of specific prevention activities and the overall PEPFAR response; c) improved data collection and reporting to inform prevention and other programs; d) surveillance in specific populations to measure changes in the epidemic; and e) in-service trainings to build capacity. In addition to strengthening SI, this comprehensive strategy will also strengthen other technical areas: laboratory, human resources for health, health systems, HIV care, and prevention by a) creating a demand for laboratory services and improving laboratory infrastructure; b) supplying evidence for appropriate resource allocation; c) improving electronic data capture and reporting; d) improving data quality, reliability, and timeliness; e) strengthening HIV clinical care; and f) improving HIV prevention programs.
The PEPFAR SI strategy includes the implementation of PLACE and BSS studies and the development of prevention programs targeting specific populations followed by monitoring and evaluation of SI activities (e.g. TraC, TraC-M, TraC+, etc.). These SI activities are described below.
• PLACE studies permits the mapping of hot spots (places where people meet their potential sexual partners) involving the general population. USG will continue to support PLACE studies in Luanda in FY10 and results may prompt further SI activities for more detailed socio cultural information (rapid assessments, qualitative studies in MARPs, BSS). In FY10 and subsequent years, USG plans an expansion of a pool of trained local researchers to implement such studies in other priority provinces.
• Results from PLACE studies (i.e. potential locations where some MARPS congregate and find new sex partners) will provide information to guide specific BSS studies. BSS are studies with socio-cultural depth including biological markers for syphilis and HIV that provide baseline data for behaviors of high risk groups. These results will constitute a baseline for second generation behavioral surveillance systems to

be implemented in country.
• Results gathered from PLACE and BSS studies will be used to support the design of new prevention messages and implement prevention strategies targeting MARPS and other vulnerable populations. These prevention interventions will be implemented and evaluated by TraC studies and/or other appropriate evaluation mechanisms. TraC studies measure changes in behavior, behavioral determinants or exposure to specific prevention activities through household, target group or intercept surveys. Development and evaluation of these prevention programs will be planned in future years once results of PLACE and BSS studies become available. There are no TraC studies planned in FY10.
The USG will also a) support national population census preparations and AIS; b) conduct a gender assessment on the national, public and private sector response to HIV/AIDS; c) strengthen registry systems and M&E systems for laboratories by providing trainings on molecular and immunological methods, sample collection, and data reporting; and d) continue to provide data analysis and data management support to the 2009 ANC survey.
The USG´s approach to future studies takes into consideration limited resources and what other data sources exist in country (MICS, pending AIS). Data and information sharing is therefore important for a cost-effective approach that should build the evidence base for targeted prevention activities. Although USG prevention efforts will concentrate in Cunene and Luanda and the trucker route between the two provinces, future interventions will be dictated by new data (ANC, AIS, MICS, PLACE and BSSs) and will also expand to other parts of the country.
The USG will continue support of FY09 initiated TB/HIV SI activities. After an initial assessment of the National TB (NTB) program, it will strengthen efforts at the national and provincial designated settings to report and record TB information, and to support a functional electronic TB register (ETR.net) to facilitate HIV-infected TB patient management, HIV surveillance in TB patients, and M&E of essential program functions and outcomes.
Other planned activities in HMIS include a) continued support to on-going data collection efforts to evaluate the effectiveness of HIV prevention programs; b) the development of innovative methods to collect data, including utilizing Palm Pilots (hand held electronic devices) to conduct surveys both in Luanda and in rural areas; c) trainings on ANC data management skills in Luanda and in 3 provinces; and d) trainings on electronic data capture and reporting in provinces where BSS studies are conducted. In FY10, the USG will explore ways to support implementation of HMIS components to increase capacity of routine health information systems based on the recent HMIS assessment conducted by MoH and funded by WHO. Based on the outcomes of this report, yet to be released, we will plan activities to strengthen HMIS that can be integrated into our comprehensive SI strategy in FY11.

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	150,000	
Total Technical Area Planned Funding:	**150,000**	**0**

Summary:
TB/HIV (HVBT) TAN Context and Background
Angola is a post-conflict country recovering from a prolonged civil war, which ended in 2002. This devastating civil strife decimated the health infrastructure. Despite important GRA efforts and significant external assistance, Angola’s health system still needs significant development as it does not provide adequate health care for the population. The country has 18 provinces. Most public resources are concentrated in the tertiary and secondary health care levels, leaving primary and rural health care centers with minimal support. Only 15% of the health work force provides services in rural areas, where over half of the population lives. The diversion of the nation's resources to fight the war and massive

population dislocations led to sustained high levels of poverty, with 21% of the population now living in extreme poverty. This poverty, coupled with low access to health services, translates to poor health conditions, particularly for women.
Angola's population is an estimated 17 million with a HIV prevalence estimated at 2.1% among the population aged l5-49. Sixty-two percent of the population is under 24 years old. During 2004-2007, prevalence among young pregnant women rose from 2.7% to 3.1% (ANC 2005, 2007). Angola is bordered by the high-prevalence countries of Namibia and Zambia. Though Botswana does not border Angola directly, the two countries are separated only by a 30 kilometer stretch of uncontrolled land, which is concerning since the increased movement between the two populations could lead to increased transmission. A review of estimated HIV prevalence by province reveals significantly higher rates (estimated at 9.4%) in Cunene along the border with Namibia. Luanda and Cunene are two geographic areas with a high concentration of MARPs.

The HIV/AIDS program in Angola has undergone major development and expansion over the past several years; however, it has not developed a systematic basis to determine the characteristics of the pandemic. In line with government policy to decentralize decision-making to sub-national levels, provincial and national forums play important roles in implementing HIV/AIDS strategies, and contribute to national and regional development planning. Since each province is unique, institutional capacities, needs, and progress in implementing HIV/AIDS strategies and the "Three Ones" principles differ considerably among them. Therefore, programmatic responses are tailored to local realities. This is particularly important in rural and remote districts of the country, which poses considerable challenges in scaling-up interventions. The USG continues to support the improvement of health management in direct collaboration with the Provincial Health Directorates of 8 high prevalence provinces (Luanda, Cunene, Kuando Kubango, Huambo, Lunda Norte, Lunda Sul, Cabinda, and Uige). This support aims at improving service delivery by scaling-up service delivery, targeting existing health care workers to improve quality, enhance leadership and management, planning, and health service supervision. The program is integrated with other USG-supported programs such as family planning, malaria and TB activities.
Challenges/Accomplishments in 09
The estimated number of people with tuberculosis (TB) in Angola doubled during 1990-2006 from 21,380 to 47, 231 and the TB prevalence is estimated to be 220/100,000 inhabitants (WHO, 2008). The DOTS strategy covers 116 of 164 municipalities, approximately 70% of the country, and lacks essential M&E of patient registry, outcomes, and program performance parameters. Based on very limited data, the MOH National TB Control Program (PNCT) estimates of HIV prevalence among TB patients was 15% in 2007 (update data), varying from 16% in Benguela to 5% in Cabinda. Therefore, HIV infection is expected to be high in patients seen in TB clinical settings, making these settings "low hanging fruit" for the identification of patients with HIV/TB co-infection and their referral for HIV prevention, care and treatment. In 2009 considerable success was achieved in coordination between the INLS, USG, and others partners involved in TB/HIV. Although improving, coordination and collaboration between TB and HIV activities needs to improve at all levels. The National Guidelines for TB/HIV are in process and expect to be finalized in 2010.
The national TB control program submitted a round 9 Global Fund proposal that totaled $25,000,000 for five years. This proposal was accepted by the Global Fund Board with 2 B status. The PNCT organized a TB symposium where the national TB strategic plan 2009-2013 was presented to an audience that included international donors, NGOs and other government organization. In FY09, PEPFAR financed one year EHSP TB activities in order to fill the gaps caused by the budget cut of non PEPFAR USG TB funding. PNCT continues to experience significant obstacles, including:
• Insufficient numbers or inadequately trained personnel to provide HIV counseling and testing;
• Inability to adequately perform M&E functions related to TB/HIV activities in TB facilities, which significantly diminishes the capacity to record and report program performance;
• Weak information systems to capture data on estimated TB and TB/HIV co-infection cases;
• Capturing HIV surveillance data among TB patients;
• Systematizing referral and follow-up of HIV-infected TB patients; and

• Monitoring, forecasting, procuring, and managing lab reagents and drug supplies for the diagnosis and TB treatment of HIV-infected patients.

In order to address the USG TB/HIV priorities of human capacity building, technical assistance for the PNTC needs to focus on the improvement of M&E functions and coordination between activities implemented by USAID's non-PEPFAR program and other entities (e.g. GFATM, WB, NGOs). In FY 2009 the USG strengthened the TB program by increasing the capacity of the PNTC and other NGOs working in TB/HIV by supporting:
• Training of personnel in reporting and recording TB information according to current guidelines, with the goal of eventually transitioning to a functional electronic TB register;
• Training personnel to serve as national trainers for a second tier of TB/HIV staff in other facilities, particularly in HIV counseling, testing, and referral of HIV-infected patients to the appropriate health services;
• Strengthening the PNCT program's TB and HIV diagnostic capacity (including the capability to perform TB culture and resistance testing for the detection of MDR/XDR TB) and the internal and external quality assurance of this capacity by supporting central reference laboratory activities;
• Facilitation and formation of a functional national TB/HIV collaborative entity between the PNCT and the INLS to oversee TB/HIV collaborative policies and activities; and
• The development and implementation of a TB/HIV sentinel surveillance system in collaboration with the PNCT and NGOs already working in this program area.

Goals and strategies for 2010
The FY 2010 COP strategies for TB/HIV are linked directly to the Partnership Framework and the Partnership Framework Implementation Plan goals, specifically, Goal 1: Strengthening capacity for an effective national response to combat HIV/AIDS.
The USG plans a thorough assessment of the national tuberculosis program, which will identify high-impact areas where synergies involving the national HIV/AIDS program, the national TB Control program, and the National Institute of Public Health can increase TB/HIV integrated activities. The USG will continue to support the development of clinical guidelines for PICT in TB facilities and train community and public health workers to serve as national trainers of trainers for HIV counseling and testing of TB patients at the provincial and municipal levels. Furthermore, TA will strengthen efforts at national and provincial designated sites to report and record TB information and to support a functional electronic TB register (ETR.net) to facilitate HIV-infected TB patient management, HIV surveillance in TB patients, and M&E of essential program functions and outcomes.
In FY 2010, the USG will specifically provide technical assistance for the following activities:
• Strengthening the technical capacity in diagnosis, care and treatment of TB/HIV co- infection;
• Expanding implementation of data collection instruments and tools for co-infection TB/HIV, M&E and surveillance, which will lead eventually to a sentinel surveillance for HIV/TB; and
• Increasing the capacity of laboratories to support HIV, TB, STIs activities.

Technical Area Summary Indicators and Targets

Redacted

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7446	Chemonics International	Private Contractor	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	1,750,000
7449	Measure Evaluation	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	300,000
10401	Charles Drew University	Implementing Agency	U.S. Department of Defense	GHCS (State)	1,100,000
11017	World Learning	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	650,000
11976	Strengthening Pharmaceutical Systems (SPS)	Implementing Agency	U.S. Agency for International Development	GHCS (USAID)	280,000
11977	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
11978	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
11979	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
11980	I-TECH	NGO	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHCS (State)	200,000

11981	Mohammed Abdullahi Wase Specialist Hospital	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	700,000
11982	CDC National Prevention Information Network	Parastatal	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	605,000
11983	Capacity Project	Implementing Agency	U.S. Agency for International Development	GHCS (State)	250,000
11984	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
11985	Association of Public Health Laboratories	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	355,000
11986	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
11987	Mohammed Abdullahi Wase	Host Country Government	U.S. Department of Health and	GHCS (State)	150,000

	Specialist Hospital	Agency	Human Services/Centers for Disease Control and Prevention		
11988	Moepathutse Children's Centre	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	150,000
11989	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
11990	Charles Drew University	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	150,000
11991	Macro International	Private Contractor	U.S. Agency for International Development	GHCS (State)	100,000
11992	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
11993	Academy for Educational Development	NGO	U.S. Agency for International Development	GHCS (USAID)	150,000
11994	Measure Evaluation	NGO	U.S. Agency for International Development		

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7446	**Mechanism Name: Essential Health Services Program I**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Chemonics International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,750,000	
Funding Source	**Funding Amount**
GHCS (State)	820,000
GHCS (USAID)	930,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The HIV/AIDS component of the Angola Essential Health Services Program (EHSP) started implementation in October 2007. The purpose of the HIV/AIDS activity is to prevent HIV/AIDS transmission in Angola by improving the national and provincial capacity to address the HIV/AIDS epidemic, and to increase access to quality VCT and PMTCT services including follow-up for HIV-positive individuals. The HIV/AIDS component was initially started in the three provinces of Luanda, Lunda Norte and Cunene. In the next year, program activities expanded to four new provinces: Cabinda, Kuando Kubango, Lunda Sul, and Huambo to work in a total of 7 provinces. In COP 10, EHSP plans to expand and work in a total of 8 provinces, prioritizing those with the highest HIV prevalence and include the above mentioned plus Uige, as well as all along the transport corridor between Luanda and Cunene.

Overall objectives of the EHSP include:

1. Improved capacity of the health system in targeted provinces to plan, budget, and deliver quality health care and services.

2. Increased individual and civil society knowledge and practice of positive health behaviors related to HIV/AIDS.

3. Increased individual and civil society demand for and participation in improving quality and health services.

Overall in FY 09, EHSP reached the majority of their targets in the areas of PMTCT, VCT and sexual prevention.

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A major achievement of the EHSP 2007 was the establishment of 30% of all new PMTCT sites within the country. EHSP aimed In FY09 to have a total of 16 PMTCT sites, but far surpassed themselves with the creation of a total of 30 new PMTCT service outlets providing the minimum package of PMTCT services according to national and international standards. Specific results include 26,197 pregnant women counseled and tested despite the challenge of enduring a several month stock out on tests kits at the provincial (DPS) level. Additionally, they surpassed their goal of number of pregnant women who were provided with a complete course of ARV Prophylaxis in a PMTCT setting. Numbers of health care workers trained also surpassed expectations. EHSP's successes were greatly enhanced by a strong working relationship between EHSP and the INLS and DPS teams.

A major achievement in FY 09 in CT was that 23,684 individuals received counseling and testing. EHSP supported a total of 23 VCT service outlets in FY09 of which 8 new VCTs providing counseling and testing for HIV according to national and international standards. Numbers of counselors trained surpassed their targets with 30 trainees.

In FY 09 EHSP, trained 48 trained individuals in institutional capacity building and trained 848 (target 200) in both HIV related stigma and discrimination reduction and HIV-related community mobilization for prevention, care and/or treatment.

In FY 09, a total of 54,505 people were reached with sexual prevention abstinence and being faithful messages, while 17,993 with other prevention messages. Prevention messages covering messages of AB and C were delivered through schools, churches and public places such as markets and relied mostly on the cascade methodology. EHSP project trained and worked with community health agents and community leaders to deliver these prevention activities.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	235,000

Human Resources for Health	995,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7446**
Mechanism Name:	**Essential Health Services Program I**
Prime Partner Name:	**Chemonics International**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	350,000	

Narrative:

In COP 10, EHSP plans to continue to scale-up VCT services to work in a total of 8 provinces; prioritizing provinces with the highest HIV prevalence. Additionally, the transport corridor between Luanda and Cunene province is a critical area of focus.

In COP 10, EHSP will increase CT in reproductive health services at the municipal level. EHSP will support the increase of CT, with expansion to both new centers and mobile clinics, in key geographic regions. EHSP will establish new VCT service sites if possible together with PMTCT by rehabilitating existing health centers with GoA, USG and GFATM funds and integrating services at government health facilities.

Specific activities include the provision of equipment and small scale refurbishment for counseling and testing services; training in Counseling and Testing including lay counselors; increased provision of supportive supervision and in-service training.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	700,000	

Narrative:

EHSP will continue to provide support to MOH in the decentralization process by providing technical assistance in the areas of finance and planning, national health accounts, and gap analysis. EHSP will work to expand quality control system at municipal and provincial levels to strengthen supervision of

health staff and community health workers. Additionally, EHSP will support the MOH to develop capacity of existing health care workers (doctors, nurses, nurse-midwives, medical assistants, laboratory technologists; pharmacy technicians) work on upgrading the clinical, leadership, management, planning, supervision, information systems, quality improvement of services, and stigma reduction skills of health care workers via in-service training at provincial and municipal levels. Collaboration with the MOH will also include support to develop a policy and plan for task shifting to nurses, auxiliaries and community health workers; the establishment of a policy for community health workers to guarantee appropriate follow up to diagnosis (both positive and negative), care and support, and treatment (adherence), and assistance in formulating a strategy to reinforce the referral system.

Some specific activities will include: the provision of technical assistance to train health personnel for PMTCT/VCT; support and management of the mobile clinic; updating national guidelines for CT policies, development of Standard Operating Procedures (SOP); an emphasis the quality of counseling; follow-up for HIV+ in treatment adherence; training of lay-counselors training; improvements of M&E for CT and the follow-up of PMTCT at the provincial level; as well as training and support to permanent staff in every of the 8 provinces to strengthen M&E and supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	150,000	

Narrative:

EHSP will scale-up community mobilization and communication activities using the successful implementation of community agents training, the link between the health services and the CHW and through capacity building of CSOs and local NGOs and church groups in prevention, care, stigma and discrimination reduction. Prevention activities, conducted mostly through community agents put an emphasis on understanding risk reduction and promoting key behavior change messages, in line with the overall National behavior change messages and campaigns. The capacity of community agents will continue to be built through training, supportive supervision, management and technical assistance, in close collaboration with the DSH and the Provincial government. Technical assistance in provision of quality AB prevention programming will be provided by EHSP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	150,000	

Narrative:

EHSP will scale-up community mobilization and communication activities using the successful implementation of community agents training, the link between the health services and the CHW and through capacity building of CSOs and local NGOs and church groups in prevention, care, stigma and

discrimination reduction. Prevention activities, conducted mostly through community agents put an emphasis on understanding risk reduction and promoting key behavior change messages, in line with the overall, National behavior change messages and campaigns. The capacity of community agents will continue to be built through training, supportive supervision, management and technical assistance, in close collaboration with the DSH and the Provincial government. Technical assistance in provision of quality other prevention programming, including STI prevention and treatment and condom promotion and distribution will be provided by EHSP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	400,000	

Narrative:

In COP 10, EHSP plans to continue to scale-up PMTCT services to work in a total of 8 provinces; prioritizing provinces with the highest HIV prevalence. The aim is to achieve 100% coverage of ANC facilities in both Luanda and Cunene province as well as the transport corridor between the cities in the upcoming two years.

Specific activities will include the on-going collaboration with GRA, USG and GFATM in order to establish new PMTCT sites by rehabilitating existing ANC centers. These sites will be integrated into existing services at government health facilities and will utilize personnel and funds from GRA, USG and GFATM. Plans are to increase CT coverage in prenatal services, and CT and PMTCT at delivery and post partum, at both the provincial and municipal levels. The EHSP will also strengthen integration and articulation with Maternal -Infant Services and Family Planning at municipal level, as well as increase the provision of reproductive health/family planning services at PMTCT sites. Activities will also include training of health staff in integrated PMTC and Family Planning services and M&E.

Increased emphasis will be placed on quality monitoring and follow-up of HIV positive pregnant women and exposed newborn, increased supervision and in-service training; and strengthened south to south cooperation.

An internal evaluation of the PMTCT package will be implemented to define future scale-up

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7449	Mechanism Name: Priorities for Local AIDS

	Control Efforts (PLACE)
Funding Agency: U.S. Agency for International Development	Procurement Type: Umbrella Agreement
Prime Partner Name: Measure Evaluation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 300,000	
Funding Source	**Funding Amount**
GHCS (State)	200,000
GHCS (USAID)	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

USAID/Angola has requested MEASURE Evaluation (under the Carolina Population Center) to conduct Priorities for Local AIDS Control Efforts (PLACE) studies in Angola. The purpose of this rapid assessment is to identify geographic areas where HIV transmission is likely to be high and where prevention programs should be focused. PLACE will provide critical information including a list of venues where people meet new sexual partners, a description of characteristics of the venues and their patrons, and information to monitor youth-focused and general HIV/AIDS prevention programs at these venues, including information about sexual behavior. The study will provide quantitative data that will inform future strategic programming for PEPFAR Angola, especially HIV prevention programs, condom promotion and behavior change interventions.

An initial exploratory visit occurred in October, 2009 and proposals from interested local research organizations were solicited, and all proposals were evaluated for cost, complexity, and experience. It was decided that MEASURE Evaluation-UNC will provide technical assistance to Population Services International (PSI) in Luanda, Angola to implement fieldwork for this study. To that end, MEASURE Evaluation, in concert with PSI, completed a full draft of the submission to the National Ethics Committee, including a study protocol, all draft questionnaires, and consent procedures. The first two study locations were also decided in collaboration with USAID and the National Institute for HIV/AIDS Prevention (INLS). Pending final approval from the National Ethics Committee, the first two studies will be carried out in Rocha Pinto (a neighborhood of Luanda) and in downtown Luanda before September, 2010. As an alternative for the last locations, a proposal is being developed to cover the whole of Luanda.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	90,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7449**
Mechanism Name:	**Priorities for Local AIDS Control Efforts (PLACE)**
Prime Partner Name:	**Measure Evaluation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	300,000	

Narrative:

COP FY10 funds will include two to five PLACE studies to cover both rural and urban areas of Angola; specific locations and number of studies will be decided in future consultation with GRA and local partner organizations. Maps produced and data collected as part of each study area will be disseminated broadly to facilitate participation and intervention development from various stakeholders and local implementing partners. Future studies are likely to include additional local partner organizations as MEASURE Evaluation aims to reduce their involvement and level of supervision so that local partners can build their internal capacity for conducting all aspects of PLACE studies..

Some examples of important capacity building efforts include intensive analysis and report writing, a stakeholders workshop to decide locations of subsequent studies, and a data use workshop for local stakeholders to generate interest in PLACE and train stakeholders in using data to inform interventions. Another objective of this approach is the training of a pool of Angolan social researchers and interviewers who can expand this initiative over the whole country in the coming years, linking research to action.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10401	**Mechanism Name: Civil-Military alliance**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: Charles Drew University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,100,000	
Funding Source	**Funding Amount**
GHCS (State)	1,100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Narrative Overview

Charles Drew University of Medicine and Science in Los Angeles, California (CDU) has been partnering with the Angolan Armed Forces (FAA) on a prevention program since 2001, and has been expanding its relationships with various organizations within Angola such as, the INLS, Agostinho Neto University (UAN) and the IPMP Instituto de Medicina Preventiva ever since.

Over the past eight years, the DoD through CDU, in partnership with the Angolan Armed Forces (FAA), has made great advances in implementing HIV prevention intervention programs; conducting focus groups and surveys to assess local knowledge and perceptions about HIV/AIDS and STIs; setting up VCT clinics; and training Angolan medical personnel in VCT counseling, HIV-related lab work, and HIV epidemiology throughout the five military regions (North, South, Center, East and West).

USG ongoing HIV prevention programs have already reached more than 40,000 military personnel through HIV prevention workshops and radio programs, as well as the distribution of condoms, brochures, HIV prevention manuals, and HIV prevention comic books and posters designed to instruct and motivate behavioral change. Through their activities, CDU aims to further increase the testing and counseling capability of the FAA by helping to refurbish and equip a total of six VCT sites in Lubango, Cabinda, Huambo, Uige and the Army and Air Force Clinics in Luanda. Using FY2009 funds, a mobile VCT will be

provided in Luanda and 1 VCT centers will be set up in Cunene in the first year of PFIP. Currently the FAA has set 1 VCT center in Cunene with Global Funds. CDU also trained the requisite counselors in the national standards for counseling and testing to provide the human resources necessary for the establishment of additional VCT centers.

CDU will continue on-going data collection efforts (through surveys and focus groups) to evaluate the effectiveness of these programs. The CDU team will use innovative methods to collect this data, including utilizing Palm Pilots (hand held electronic devices) to conduct surveys both in Luanda and in rural areas. Additionally, the research team has conducted focus groups to address the prevention needs of the spouses of military personnel.

CDU collected data about HIV prevalence and risk behaviors among Angolan military personnel in four locations throughout the country in 2003, gaining much-needed information to guide prevention efforts. The results of the 2003 BSS showed that the infection rate in the Angolan Military was approximately 3.6%. The results also showed higher infection rates in the capital and cities along the Angolan border and very low rates in the center of the country where people have remained fairly isolated.

CDU will conduct another BSS with HIV testing among the military using FY2009 funds in calendar year 2010. CDU will continue to analyze the HIV prevalence data to learn where prevention programs are most needed.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	56,000
Human Resources for Health	540,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10401**
Mechanism Name:	**Civil-Military alliance**
Prime Partner Name:	**Charles Drew University**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	300,000	

Narrative:

Through their activities, CDU aims to further increase the testing and counseling capability of the FAA and will continue efforts by implementation and expansion of VCT services. Scale-up of VCT coverage in the military will be accomplished by expanding the number of VCT clinics by three for a total of nine. Currently there are six operational VCT centers in Luanda, Cabinda, Lubango, Huambo and Uige. Using FY2010 funds a mobile VCT and two fixed VCT centers will be established in Kuando Kubango and Benguela.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	520,000	

Narrative:

The FAA conducts mandatory HIV testing for new recruits and before deployment for peace keeping missions overseas. The FAA is concerned that many of their HIV-positive personnel come for medical assistance too late to receive the care needed to prolong and improve life. Because care and treatment are centrally located and the military population is mobile, tracking patients and ensuring follow-up (e.g. ARV adherence) are difficult.

With COP FY2010 funding CDU will design and implement psychosocial programs to address the psycho-emotional needs of those identified as sero-positive and to improve the rates of adherence for those already in treatment. These psychosocial programs will include prevention education designed specifically to target already HIV-infected persons to help keep their loved ones, family members and sexual partners safe. CDU's prevention efforts with the Angolan Armed Forces are ongoing, and USG aims to reach more military personnel by expanding our programs.

CDU will implement prevention activities in training physicians in ARV techniques and other health professionals in prevention for positives in the Angolan Armed Forces. 10 in-service military personnel will be trained in hospital management/administration and peer education techniques related to HIV prevention, transmission, and testing. Technical assistance will be provided to the military in data management, laboratory and clinical mentoring. Policy reform will be addressed with emphasis on the rights of HIV positive service men to fight stigma and discrimination. Advocacy is increasingly becoming an important activity of DoD through CDU in an attempt to motivate the FAA to create sustainable prevention activities and programs. USG will also assess the potential for clinical mentoring between the US Navy Medical Center in San Diego and the FAA Health Division.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	80,000	

Narrative:

CDU will continue to train HIV activists in AB for the Angolan Armed Forces. Military personnel will be trained by expert CDU Master Trainers in peer education techniques related to HIV prevention, transmission, and testing. CDU will continue engagement with top level officials of the Angolan military to maintain a sense of urgency in the promotion of behavioral change and awareness of the threats posed by HIV, both to military forces and to the society in general. CDU has created prevention messages and materials that directly target military commanders, enlisting their support to help facilitate positive prevention messages among their soldiers. Advocacy is increasingly an important activity of CDU to motivate the FAA to create sustainable prevention activities and programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	200,000	

Narrative:

The BSS conducted in 2003 revealed that the availability of condoms, however, is varied from region to region. While condoms are easy to access in larger cities, there are virtually none available in smaller towns and villages. Even where condoms are obtainable, many of the men do not carry them or have them available at the time of their sexual encounters. According to focus group participants, they are afraid they will lose their opportunity for sex if they go off to find a condom.

Based on available information, making condoms available and motivating military personnel to carry and use condoms regularly are key components in the battle against HIV/AIDS infection. Currently, the FAA receives its condoms from the INLS or procures them through their own budget. Taking into account that the GTATM Round 9 proposal was rejected for Angola, it is very likely that the FAA National budget and resources will decrease substantially in coming years. In FY2010, the DoD intends to use the USAID central contraceptive mechanism to procure condoms for the FAA. Such distribution of condoms will more effectively link to peer education activities and condom use in every military region.

CDU will work with the FAA to design educational materials and deliver health messages to armed forces. CDU provides training for lower level officers in the production of HIV prevention radio scripts, story development, and message production thus creating an independent team that can develop mass media messages from start to finish and is technically equipped to air these messages on the military radio hour through the National Radio Station (RNA). CDU's prevention efforts in the Angolan Armed Forces are ongoing, with the aim to reach more military personnel by continuing and expanding program

activities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11017	**Mechanism Name: Civil Society Strengthening**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: World Learning	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 650,000	
Funding Source	**Funding Amount**
GHCS (State)	200,000
GHCS (USAID)	450,000

Sub Partner Name(s)

Acçao de Apoio das Populaçoes Vulneraveis – ADESPOV in Caála.	Acçao de Solidaridade e Desenvolvimento – ASD in Lubango, and	Accao Humana
Acção para o Desenvolvimento, Combate e Exclução Social e Vulneravel – ADCESV in Ondjiva,	Cuidados da Infancia in Viana,	Grémio ABC in Cabinda,
RNP +		

Overview Narrative

The HIV component of the Civil Society Strengthening Program in Angola started implementation in 2007. World Learning is currently providing small sub-grants to six Angolan organizations working in HIV/AIDS in the areas of prevention, care, and advocacy. Furthermore, World Learning is strengthening the institutional capacity of these six organizations along with an additional 30 for a total of 37 CSOs working in HIV/AIDS prevention, care and advocacy in the provinces of Benguela, Bie, Cabinda, Cunene, Huambo, Huila, Kuando Kubango, Luanda and Lunda Norte. The primary beneficiaries of these CSOs are

youth, PLWHA and pregnant women. Sub-grants are provided to implement the following specific activities:
• 1 small sub-grant to the Network for People Living with HIV/AIDS to "increase free access to antiretroviral therapy services to people living with HIV/AIDS";

Accomplishments during FY09 include the initiation of the south to south initiative and the RNP+ start up of the waiting house, which made it possible for over 2,000 people, including pregnant women, to access to antiretroviral therapy services they otherwise would not have.

Furthermore, a series of project and survey reports by a local CSO was compiled and used to inform parliamentarians in their deliberations regarding revisions to the HIV/AIDS Law.

During FY 09 World Learning established Monitoring and Evaluation Systems with target CSOs, which included databases to monitor project activities and internal operations for human resources and financial management. Target CSOs also developed administrative systems and procedures for the first time, including the development and use of administrative manuals. A total of 30 local CSOs were given technical assistance for HIV policy development and 140 individuals were trained in advocacy and reducing stigma and discrimination.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11017**
Mechanism Name:	**Civil Society Strengthening**
Prime Partner Name:	**World Learning**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	350,000	

Narrative:

None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	300,000	
Narrative:			
Partnership Framework Funds Through cross border programs the USG will give support to PLWHA Networks to promote ANC utilization and testing for pregnant women, follow-up for HIV positive women, and take advantage of exchange of experience. This program is additionally strengthening gender initiatives, through encouraging men to be tested and to participate in the health care of the family.			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11976	**Mechanism Name: SPS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Strengthening Pharmaceutical Systems (SPS)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 280,000	
Funding Source	**Funding Amount**
GHCS (USAID)	280,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

FY 10 Funds

USG will provide TA for improving the logistics and drugs management in Angola, specifically ARV's, test kits and condoms logistics. Programs suffer from a very weak pharmaceutical supply system at the national as well as the local levels. Health programs have recently experienced difficulties in reaching set targets due to stock out in and test kits, due to poor management, weak logistics systems and thefts from

warehouses.

The USG PMI program conducted an assessment in 2005 and as result of the assessment, it was determined that PMI support would include working with the Essential Drug Program to develop the basic pharmaceutical management systems of the MOH. PEPFAR will work in coordination and collaboration with the MOH, the National Malaria Control Program, PRI, WHO and other partners to expand ongoing TA support to ARV's, test kits, condoms, and lab commodities

The overall strategy is to avoid creating a parallel supply system outside of the existing MOH supply system and isolated from other donor programs. An initial assessment will define how USG can best support the MoH and the INLS in this area, for example in the development of a national distribution plan for ARVs. Given the relatively weakened conditions of the MOH system, it is expected that USG support will provide technical support and capacity building to strengthen these systems when appropriate. The main counterpart for this activity is the INLS' National Essential Drugs Program (EDP) which is responsible for the national distribution of essential drugs kits. EDP currently receives technical assistance from PRI, the European Union and WHO. EDP and the INLS coordinate on a variety of issues at the national and provincial levels for ARV, test kits and condoms management.

This activity started in FY 09. The assessment will take place in FY 10 and the implementation activities will be defined and carried out based on specific findings from the assessment.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11976**
Mechanism Name:	**SPS**
Prime Partner Name:	**Strengthening Pharmaceutical Systems (SPS)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Other	OHSS	280,000	

Narrative:

Initially, the focus of these activities will be at the central level and then later at provincial levels. These implementation efforts will be strategically phased or staggered over time as systems are put into place and capacity of personnel is developed. Additionally, PEPFAR and other partners will assist the MOH to manage existing in-country stocks of ARVs, test kits, condoms, and lab commodities.

Specific activities in the overall program will include assistance with purchase, warehousing, distribution and the monitoring of this process. Key to success will be efforts to coordinate partners and their procurements for optimal coverage. Additional focus will be on the optimal scheduling of the shipment deliveries for on going product supply, revision to the quantification process using consumption data from health facilities, improving monitoring of suppliers, their performances and adjusting distribution schedules accordingly as well as administrative accountability. Critical outcomes of this activity will be to estimate the funding gaps for national and continuous ARV's availability, to define distribution routes, transportation means and estimate costs, to provide TA for improving national and provincial storage facilities and/or determine alternatives with cost estimates, and to develop mechanisms to minimize leakages from the public sector.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11977	**Mechanism Name: Community Based Prevention**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted

Funding Source	Funding Amount
Redacted	Redacted
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The USG will initiate a comprehensive, multi-faceted prevention program to promote normative change and adoption of safe sexual behaviors, with the aim of reducing new HIV infections among general population adults, youth, and high-risk groups.

The sexual prevention program will require concerted attention to the general population while concentrating on specific targeted populations such as youth (<15, 15-24) who represent 60 percent of the population, and the highest risk populations. The common practice of multiple concurrent partners (MCP) is an important driver. Additional key drivers of the epidemic include high rates of unprotected sex, either low and or inconsistent condom use in sexual relationships, and low perception of risk, though data needs to be strengthened to better understand the dynamics of the epidemic.

In Angola's PFIP, there are three main prevention packages: prevention package for the general population, prevention package for youth, and prevention package for MARPs. To avoid vertical programming and in order to achieve the maximum results with limited funds, it is important to focus efforts in an efficient, comprehensive and integrated manner. In terms of the implementation of these three packages, USAID's prevention efforts will be split into two main projects and a targeted intervention, one geared towards the general population and youth in the community, one reaching Angola's MARPs/highest risk-groups, and one geared towards the higher-risk general population at hot spots. A gender lens will be integrated into all activities, recognizing that cultural and gender norms may reinforce key drivers of the epidemic such as multiple and concurrent partners and transactional sex.

Other key considerations for program design and implementation include undertaking a good epidemiologic analysis. This is especially critical for Angola, as there is little data and in-depth understanding of risk behaviors, groups and key drivers. Not only will this analysis help identify groups at higher risk, it will also help with the market segmentation of BCC messages. The PLACE study will provide critical evidence for targeting services and messaging and will assist with the design of the various components of the community-based response. Special efforts will be placed on training community health workers to engage in outreach for follow up of HIV+ people. The new community-based prevention program which integrates the general population and youth packages, has the following key objectives:
1) Supporting and developing an effective community-based prevention response with an emphasis on BCC and creating critical linkages with the community;
2) Developing and implementing a comprehensive life-skills curriculum at the primary and secondary

school level;
3) Strengthening mass media efforts at the national and community level to raise awareness, decrease stigma and discrimination, and create demand for services, while emphasizing GBV;
4) Strengthening and expanding the condom social marketing program; and
5) Capacity building for the CBOs, youth centers, FBOs and traditional leaders to implement comprehensive, community-based prevention programming.

Objective 1: The community-based prevention activities will reach the general population with a strong focus on youth by improving individual and community understanding of the risks of HIV infection, scaling - up HIV prevention and health promotion, and expanding critical services, including condom programming and BCC/IEC messages. Community-based activities will be linked to scaled up VCT, STI, PMTCT and other reproductive health services at various levels. Concerted efforts will be devoted to reducing alcohol use/abuse, as this is a known factor related to gender-based violence, forced and/or unprotected sex.

In order to achieve successful delivery of these activities, engagement of youth centers (i.e. Jangos), civil society, traditional leaders and the faith-based community will be critical. Additionally, linkages to and promotion of related HIV clinical services are key components of this response. The Jangos will adopt a community approach leveraging and collaborating with the private sector and other influential actors in their respective communities such as schools, churches, and police. These new partnerships will allow for a comprehensive approach and will build linkages, referral and promotion for services, and re-orient focus to interventions for transactional sex, and gender negotiation.

Program activities and messages will aim to increase individual's risk perception, BCC directed to the sexual networks that drive transmission; especially in high risk sexual encounters by HIV-positive persons, and include efforts to increase the age of sexual debut. The package of interventions will be based on evidence and use proven technologies and approaches. Interventions will be grounded in local culture to address epidemic drivers through clear, specific, consistent messages and behaviors and social norm change approaches, and to address underlying gender dynamics and norms.

The paragraph below has to be rewritten!

Effective BCC efforts and messages need to be coordinated, and aim to reinforce messaging through five arenas: Mass media, community level capacity building, peer education, in/out-school youth and provision of reinforcing prevention messages within the clinical arenas of VCT and PMTCT. The interaction between national and local mass media, community mobilization, and interpersonal communication interventions and how to link them effectively while targeting specific populations with tailored messages

will be important to address. In Angola, there exists a need for a reinvigorated and strategic BCC effort and the work of the USG at the community, individual and National level (providing support to the INLS) should help to support this.

Objective 2: Youth prevention will target boys and girls, in and out of school, with specific activities and messages to modify behaviors, values and cultural practices that put young men and women at risk of HIV. To support this intervention, an assessment of male and female norms and practices among youth (<15, 15-24) groups will be carried out to document cultural/sexual practices and vulnerabilities of boys and girls, and young men and women, providing a basis for comprehensive prevention activities, including the provision of youth friendly health services.

All of the youth-focused interventions outlined in the Overview Narrative will be undertaken in collaboration with Ministry of Education, Ministry of Youth and Sports, and Ministry of Health, specifically to:

• Develop life skills curricula in schools, including sexuality and an emphasis on sexual harassment;
• Improve school-based reproductive and sexual health services;
• Engage parents and actively involve them in activities to support a healthy environment for their children; and
• Integrate other key components of school-based programming (see budget code narrative for more details).

Objective 3: The mass media components should include both community and national level efforts and include serial dramas, call-in shows, spots, billboards, print etc. and the use of role models (famous musicians or sport figures) to emphasize risk reduction prevention messages. All of these messages used in the community-based BCC efforts should be aligned with national campaigns and messages and use and/or adapt existing materials and resources when appropriate.

Currently, the INLS develops and implements national level informational and behavioral change with financial support from other donors. These efforts while, technically sound, are ad-hoc and lack innovation and varied means of delivery. It is envisioned that the USG will provide additional technical support to re-invigorate the national BCC response with new and creative ideas and to improve coordination between the national and community levels to ensure consistent, high-quality materials, messaging and BCC activities. BCC interventions messages, approaches and materials targeting general population adults and youth will be revised on the basis of available data.

Objective 4: This TBD project will be the lead organization implementing the Condom Social Marketing project for the entire USG program. This TBD will continue to improve the targeting and uptake, efficiency

and sustainability of condom social marketing (CSM). Activities to ensure continuity in the supply of condoms, with increased focus on condom promotion and sales in high-risk populations and communities.

This TBD will implement all condom social marketing activities for the USG and their partners. They will be tasked with collaborating and providing this expertise to all relevant USG prevention partners. This will continue to ensure continuity, consistent implementation and quality of the intervention.

Objective 5: The community prevention program for youth and general populations will build the capacity and leadership of the Angolan government and civil society institutions to plan and implement effective prevention interventions at the community level. The program will promote sustainability by engaging individuals, communities, and leadership to encourage ownership of activities and results. Key principles will include using resources effectively and strategically; achieving quality, scale and scope; strengthening systems; and using existing structures to ensure sustainability beyond PEPFAR. It will create synergies through effective linkages with other partners, programs, and activities.
This project will provide technical assistance and sub-granting to CSOs at the community level to implement effective prevention activities (mentioned above). Capacity building will be provided to CSOs and in the future to the Jangos and will include areas of organizational, technical and programmatic capacity. Additional training will focus on community health workers and traditional leaders who can disseminate information to their communities.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	Redacted

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11977**
Mechanism Name:	**Community Based Prevention**
Prime Partner Name:	**TBD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVAB	Redacted	Redacted

Narrative:

Interventions will complement the HVAB activities including:
• BCC directed towards sexual networks that drive transmission, BCC and IEC messages, approaches and materials will be revised and reinvigorated based on available, new study data, and proposed assessments. Peer counseling protocols and messages will be revised to emphasize the four transmission routes (fluids) and individual risk behaviors.
• Activities with the Jangos will focus on specifically tailored messages and customized activities to reach both in and out of school youth through both centers and outreach activities with an emphasis on gender norms, behaviors and vulnerability for HIV and will provide boys and girls with gender neutral skills such as computer and language training. Messages will include abstinence, secondary abstinence and fidelity components.
• Develop life skills curricula, that include updated components on sexual education to include gender, GBV, and HIV/AIDS, specifically addressing teacher training, reduction of sexual harassment and abuse in the school environment, and provision of peer counseling in schools. New modules include girls' empowerment, safe sex negotiation skills, secondary abstinence, self-esteem building, and related skills building. Components to emphasize for males include male norms, cultural peer pressure, and men as "future partners." Promote the increased and on-going involvement of parents. Critically review the role of teachers, existing and needed school based policies to protect students from sexual coercion; based on the review, provide a systematic process for addressing the issues and mandatory training for teachers.
• Create and support of innovative AB-related messages, campaigns, resources, materials. Examples include seeking to work with the private sector (i.e. the mining companies, cell phone providers, oil companies, etc.).
• Cooperation and coordination with community leaders, parents and teachers and other groups and individuals on HIV prevention, BCC. Capacity building efforts for civil society will include technical support on BCC efforts focusing on A and B and related (i.e. gender and alcohol).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

Interventions will complement the HVOP activities including:
• All condoms and other prevention efforts, including B and C messaging, alcohol messages and gender related activities. Critical focus will be on interventions addressing reduction of MCP, and consistent and correct condom use, especially in high risk sexual encounters and by HIV-positive persons.
• Small grants programs to work with community leaders, parents and teachers and other groups and individuals on HIV prevention, BCC. Capacity building efforts for civil society will include technical

support on BCC efforts focusing OP and related (i.e. gender and alcohol).
• Develop life skills curricula, which include updated components on sexual education to include gender, GBV, and HIV/AIDS, specifically addressing teacher training, reduction of sexual harassment and abuse in the school environment, and provision of peer counseling and condom distribution in schools. Improve school-based reproductive and sexual health services; promote youth-friendly health services, in partnership with the MOH and the provincial and municipal health services, including expansion of VCT, STI and follow-up referral for reproductive health services.
• School-based programming will critically review the role of teachers, both positively and negatively, existing and needed school based policies to protect students from sexual coercion and provide a systematic process for addressing these issues, and mandatory training for teachers.
• Also reach out of school youth and street youth with tailored messaging and activities
• Activities in collaboration with the INLS will include the creation and support of innovative and creative promotion of HIV services and related BCC campaigns at the National level, including campaigns, resources, and materials. Examples include collaborating with the private sector, support of national efforts, specialized campaigns, one-off activities such as events for World AIDS Day, national testing day, events during Africa Cup, stigma and discrimination campaign.
• Condom social marketing efforts will continue to reach MARPs and high-risk general population and will expand, as possible to more venues where people meet each other looking for sexual relationships (as informed by the PLACE studies).
• Activities with the Jangos will focus on specifically tailored messages and customized activities to reach both in and out of school youth through both centers and outreach activities with an emphasis on gender norms, behaviors and vulnerability for HIV and will provide boys and girls with gender neutral skills such as computer- and language. Messages will include abstinence, secondary abstinence and fidelity components.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11978	**Mechanism Name: Condom Social Marketing TBD**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The overall knowledge of HIV and means of protection is low in Angola. Data indicates that the main reason for the generally low and inconsistent condom use in Angola derives from social/cultural reasons rather than lack of information. It is very common for couples in established romantic relationships, to initially use condoms and then stop when they perceive that trust is established. Among other target populations, such as Commercial Sex Workers (CSW), data shows a similar pattern with recurrent clients who demand unprotected sex in exchange for higher payment. This is an example of how social and gender norms give men the power of decision making, leaving women with limited negotiating power. The USG team believes that social, cultural and gender norms need to be taken into consideration when addressing the marketing and promotion of condoms.

The PEPFAR program in Angola is initiating a comprehensive, multi-faceted prevention programs to promote normative change and adoption of safer sexual behaviors, with the aim of reducing new HIV infections among the general population, including youth and most at risk populations (MARPs).

The purpose of the project is to ensure the availability of condoms; both commercial and generic for prevention interventions, specifically in areas considered "hot spots" are which crucial forums for targeted prevention activities. To avoid vertical programming and in order to achieve the maximum results with limited funds, it is important to focus efforts in an efficient, comprehensive and integrated manner. In terms of the implementation of prevention, USAID's prevention efforts will be split into two main projects; a Community Based Prevention Project targeting the general population, including a specific focus on youth and a Comprehensive Prevention Project targeting MARPs. Additionally, USAID also supports an integrated health system strengthening project which aims to improve service delivery and increase capacity of health staff.

Upon further discussion with the USAID and PEPFAR interagency team, it was realized that a Condom Social Marketing intervention was a gap in the program and was needed to strengthen the services and outreach interventions in both the MARPs and Community Based Prevention projects. A gender lens will

be integrated into all activities, recognizing that cultural and gender norms may reinforce key drivers of the epidemic such as multiple and concurrent partners and transactional sex and the need for specific marketing campaigns to reach these sub-populations.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	Redacted

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11978**		
Mechanism Name:	**Condom Social Marketing TBD**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	Redacted	Redacted

Narrative:

This program will primarily focus on the B and C components of an ABC approach. FY10 funding will be used to support these key components of the intervention:

• Promotion of condom use, linked to a national system for condom social marketing and a national distribution system of free condoms.

• Condom social marketing of branded condoms at the national level, with efforts in key geographical areas and key populations.

• Distribution of generic condoms with targeted messaging. Experience shows that branded condoms for sale and unbranded condoms distributed for free cater to different target groups and as such constitutes complementary strategies. This activity will coordinate with other PEPFAR Prevention Interventions, GRA/INLS, Civil Society and other stakeholder both nationally and locally to link condom distribution and BCC and ensure that prevention interventions have condoms available for promotion and distribution.

• BCC efforts linked to the overall national strategy, including additional information, discussion and messages on alcohol/substance abuse and gender issues (GBV, social and cultural norms) promotion, referral and linkages to C&T, PMTCT and other related services

• On-going efforts and emphasis on using the data collected from the PLACE, and other relevant studies, for program design, and on-going quality refinement and improvement. • Emphasis on monitoring and evaluation efforts and scale-up as appropriate

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11979	**Mechanism Name: MARPs**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

PEPFAR Angola will initiate a comprehensive, multi-faceted prevention program to promote normative change and adoption of safer sexual behaviors, with the aim of reducing new HIV infections among general population adults, youth and high-risk groups. The program will align with GRA priorities and directly support the Prevention Thematic Area of the Partnership Framework, especially as outlined in Goal 2. Reduce the spread of the HIV epidemic, objective 4: Increasing number of people adopting safe sexual behaviors.

Specifically, the USG prevention portfolio in Angola will seek to:

- Reduce risk behaviors such as early sexual debut, multiple concurrent partners (MCP), transactional, commercial sex, inconsistent condom use, gender-based violence (GBV), and sexual risk associated with alcohol use.
- Use gender-sensitive approaches to reach high risk groups such as youth and adults engaged with

multiple concurrent partners, including, mobile population (e.g. truckers, military and police), and areas of high concentration of sex workers.
- Target geographic areas/hotspot venue including areas of high population density such as Luanda, border areas such as Cunene, and transportation corridors such as from Cunene to Luanda.
Angola has a mixed HIV/AIDS epidemic. HIV/AIDS data available show a slightly higher prevalence among women than men, with a principal transmission method being heterosexual sex, as described in the sexual prevention TAN. There are an increased number of cases in provinces near the borders and cities with high population density, such as in Luanda. This trend is associated with the population mobility, poverty, the limited access to primary health care, as well as sexual practices (UNGASS 2007). The prevention program will require concerted attention to the general population while simultaneously concentrating on specific targeted populations such as youth (<15, 15-24) who represent 60 percent of the population, and the highest risk populations. Considering that the main mode of transmission is heterosexual sex; and the common practice of multiple concurrent partners (MCP) is an important driver, though data needs to be strengthened to improve the understanding of the dynamics of the epidemic. Additional key drivers of the epidemic include: high rates of unprotected sex, either low and or inconsistent condom, or low perception of risk. Commercial sex workers, their clients and mobile workers (including truck drivers, miners, military personnel and the police) are assumed to be the most at risk populations in Angola. HIV prevalence among sex workers was reported at 23.l percent (UNAIDS 2008). Little is known about men, who have sex with men (MSM) in Angola, but studies are planned, and there is government support for this work. Although there is little data on prisoners they are a population of concern, as are most vulnerable youth. IDUs are not known to be a MARP in Angola.
In Angola's PFIP, there are three main Prevention packages outlined: prevention package for the general population, prevention package for youth and prevention package for MARPs. To avoid vertical programming and in order to achieve the maximum results on an epidemic with limited amount of data, it is important to focus efforts in an efficient, comprehensive and integrated manner. In terms of implementation of these three packages, USAID's prevention efforts will be split into two main projects and a targeted intervention, one geared towards general population and youth in the community, one reaching Angola's MARPs/highest risk-groups and one geared towards higher-risk general population at hot spots. A gender lens will be integrated into all activities, recognizing that some cultural and gender norms reinforce key drivers of the epidemic such as multiple and concurrent partners, gender based violence and transactional sex.
Well-structured prevention interventions will be directed to difficult and hard-to-reach locations in the country. For each of these specific populations a distinct prevention package is needed. Each package will contain the components of condom promotion, procurement and distribution, tailored messages on prevention, expansion of HIV voluntary counseling and testing, STI prevention and treatment, stigma reduction for people living with HIV/AIDS, gender equity, and reduction of gender-based violence.
Although the proportion of people using male and female condoms rose in recent years, the uptake is still

low, and efforts to increase correct and consistent condom use will be strengthened. People living with HIV in these targeted communities are a further priority. Interventions will be customized for different risk groups based on their respective needs.
• The overall goal of this project is to ensure delivery of a comprehensive package of services for MARPs: There is substantial evidence for the effectiveness of a comprehensive package of interventions for populations most-at-risk for HIV, including commercial sex workers, their clients and other high risk populations.

The program will also incorporate linkages to "MARP-friendly" health services, especially referrals to HIV care and treatment which is provided by the GFATM and GRA, given high prevalence in these populations. These linkages may also include referrals substance abuse services, PMTCT (including family planning), and post-exposure prophylaxis as available and appropriate to meet the needs of each vulnerable group as appropriate. Sensitization of health care providers to provide MARP-friendly services will also be a critical part of the package. The program will explore opportunities and linkages with other implementers to bring mobile HIV testing services to locations that are convenient to MARPs.
Due to stigma and discrimination, and a lack of data on MARPs in Angola, thus far HIV-related services have not focused significantly on most at-risk populations. Existing data on HIV in Angola and anecdotal evidence from organizations serving MARPs and other prevention efforts indicate that commercial sex workers, clients of sex workers and mobile men are at significantly increased risk for HIV infection. Although there is a clear need for more systematic data on these populations, the limited data available suggests a mixed epidemic, with various geographic hotspots and MARPs bridging into the general populations. Additionally, due to limited data, there are no reliable estimates of the size of these MARP/high risk populations or mapping of their locations.
Anecdotal evidence suggests that sex workers continue to have unprotected sex, usually at the paid request of their clients. Because MARPs often have sexual contact with the general population, neglecting the prevention needs of MARPs spurs a continual reservoir of new HIV infections in the country. In order to effectively address the HIV/AIDS epidemic in Angola, it is essential to address both the needs of the general population at risk of HIV and those of specific MARP groups.
In FY 08 and FY09 USG supported NGOs that brought BCC and condoms to CSW and truckers in particular. TraC studies were implemented after some years of intervention and show only little change. More in-dept studies were planned and executed to come to more effective interventions that really will lead to behavior change and not only to more knowledge. The National Network of PLWHA was supported to advocate for better services for PLWHA and interventions (PwP) were planned. All involved local NGOs received institutional capacity building to improve their management and M&E.
Plans for FY 10 will include a continuation of existing MARP focused activities. These existing activities will continue to focus on CSWs, their clients and truckers. Strengthened and expanded activities that reach additional MARPs both in the groups defined above and new key MARPs will be defined and

designed, in line with the Prevention strategy in the next five years. Project interventions are likely to be targeted in year one, in order to conduct all of the planned and critical data collection efforts. Based on the results of the data collection and studies, the MARP program will be further defined and expanded and will collect additional data including mapping exercises if needed to inform the design of MARPs activities.

Specifically this project will work to scale-up the delivery of this package to MARPs in priority prevention areas in selected geographic areas through collaboration with local MARP focused organizations. The program will use data and information derived from current and planned studies and program monitoring to strengthen service delivery and to propose additional innovative approaches to reach MARP with prevention services.

Key objectives of this prevention project for MARP/high risk populations include:

Objective 1

Reduce risk of HIV among MARPs and bridge populations by increasing consistent condom use and the adoption of safer sexual behaviors.

The project will expand and increase quality of interpersonal communication and outreach to promote essential elements of HIV prevention—behavior change, products and services—that targeted populations require to protect themselves from new infections (or, given their higher rates of infection, to prevent others from being infected.)

Objective 2

Expand and increase uptake HIV counseling and testing targeted to hard-to-reach populations, and strengthen linkages to other HIV and health services.

The emphasis will be on expanding demand creative and innovative approaches to providing CT for populations who may not access services, due to stigma discrimination reasons, at mainstream clinics; strengthening screening and treatment of sexually-transmitted infections (STIs); and referral for HIV care and treatment and other services.

Objective 3

Continue to improve targeting and uptake, efficiency and sustainability of condom social marketing (CSM) and provision of and access to public sector condoms.

Support and link to existing CSM activities to ensure continuity in the supply of condoms, with increased focus on condom promotion and sales in high-risk populations and communities. Support linkages and distribution of free condoms through peer education and outreach components.

Objective 4

Strengthen capacity of government, civil society and the private sector to deliver comprehensive HIV services for high-risk populations and to create an enabling environment for service expansion.

In the Angolan context, where sex between men and commercial sex remains taboo and stigmatized and possibly punishable by law, HIV/AIDS programs must enlist the explicit cooperation of law enforcement, health authorities, and the political and religious communities, to reduce the fear of arrest and

stigmatization that cause MARPs to avoid health seeking behaviors. Critical advocacy efforts will focus on mobilizing key stakeholders, including government, civil society and members of targeted populations, to create a legal, political and social environment where MARPs can be reached with effective prevention programming. The project will help strengthen government coordination of programming for MARPs, and enable local NGOs and community-based organizations (CBOs) to advocate and mobilize resources for, and to deliver appropriate services to targeted populations in close collaboration with GFATM (through a possible extension of round 4).

The program will look to partner with commercial sex workers, MSM and human rights organizations and networks, in order to spearhead advocacy for policies to reduce barriers for the delivery of services. A range of local, national and regional stakeholders will be encouraged to assume leadership for advocacy efforts, so that this policy work is sustainable beyond the life of the project. The program will support stakeholders by ensuring timely and accurate use of data for policy work and advocacy, and for evidence-based decision making.

This project will provide sub-grants and capacity building to a variety of CBOs, CSOs, networks and other key stakeholders related to MARPs. The transfer of knowledge and skills required to operate efficient, cost-effective, accountable and transparent organizations is essential to managing integrated interventions for MARPs and high-risk populations. Moreover, solid organizational performance is fundamental to the short and long-term success of the provision of and scaling up of interventions. Capacity building efforts should work to meet the particular organizational development needs of target organizations. Capacity-building will cover a broad range of substantive areas, ranging from advocacy to administration and finance, governance, leadership, management, networking, and strategic planning. Particular attention will be given to monitoring and evaluation, supportive supervision and quality assurance, given the importance of the quality of interventions to achieving successful behavior change.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	Redacted
Human Resources for Health	Redacted

Key Issues

Workplace Programs

Budget Code Information

Mechanism ID:	**11979**		
Mechanism Name:	**MARPs**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	Redacted	Redacted
Narrative:			
Specific activities will include the provision of a comprehensive package of services to MARPS and those at highest risk, including targeted condom (male and female) and lubricant promotion, peer education and outreach, HIV counseling and testing, risk reduction activities and counseling, STI diagnosis and treatment as well as the establishment of other MARP friendly services. Additional components include the use of data for evidence-based programming and the inclusion of the target populations in the planning, design, implementation and evaluation phases of programming; policy and advocacy activities and capacity building efforts of CSO, CBOs and related Networks.			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11980	**Mechanism Name: TWINNING I-TECH**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: I-TECH	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHCS (State)	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

ITECH works increasingly on projects that twin universities. Partners are assisted to improve the quality and relevance of pre-service education for a range of health care professionals, including graduating physicians, clinical officers, nurses, social workers, psychologists, and lab technicians. ITECH provides competency-based HIV and AIDS curricula for nursing and medical schools, including technical support to schools in several developing countries across the globe to integrate infectious disease-related content into their training. In Angola, ITECH will provide the technical assistance required for health care professions training with an initial emphasis on the most established public universities in Angola, which are Luanda and Huambo.

The Angola MOH programs require additional staff in various technical areas, but a description of the profiles needed and the tasks/scope of practice responding to the needs of the country are not well defined. There is a need to update the pre-service syllabi of health care providers, but the process has taken more than four years when coordinating with the Ministry of Education (MoE). Technical assistance is needed to move this process forward. The secretariat of higher education based out of the MoE regulates all higher education in the country. The MoE conducts these health training, accredits the teaching system and defines the career categories in Angola The MoH manages 18 training institutions for mid-level practitioners, and opened five health schools in different provinces with an emphasis on basic-level training There is presently a plan in place to eliminate basic-level staff through promotion programs that will upgrade them to mid-levels. The MoE hopes to reinforce the technical competencies of the trainees / health professionals.

Senior-level training provided by the Faculty of Medicine at the Universidade Agostinho Neto train nurses, physicians, and lab technologists with an emphasis on physicians and graduates about 80 – 90 students annually. The Instituto Superior de Enfermeria (ISE) trains nurses. The government recently opened five more medical schools in different provinces under the government's decentralization plan, which includes the training of health providers. The government's plan is to graduate approximately 400 physicians annually within the next 4 to 5 years in different regions. It is hoped that this will contribute to retention of health staff in their home areas and stimulate research and other academic capacities in the region.

Until now, most senior level nurse graduates have been managers. For those who have specialized in teaching, their scopes of work have been clear. However, confusion exists around those conducting clinical work because there is not a clear distinction of roles among the different categories of nurses (basic, mid-level and high level). Most difficulties occur for those graduates who are employed at public health facilities where there is no tradition for placing high-level nurses in facilities as health care providers. In private clinics nurses typically manage the facilities and care for specialized cases.

Regarding the inclusion of HIV content in the nursing curriculum, there is an integrated course on Sexually Transmitted Infections (will become Infectology in future courses), which covers HIV content. Currently, only physicians are authorized to prescribe ARVs, although this is a debate whether this will

continue. The Faculty of Medicine and the ISE should work closely together in this area to maximize on efficiency and resources.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	11980		
Mechanism Name:	TWINNING I-TECH		
Prime Partner Name:	I-TECH		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	200,000	

Narrative:

For each pre-service initiative, ITECH is positioned to provide the technical assistance required for health care professions training in Angola with an initial emphasis on the most established public universities in Angola situated in the provinces of Luanda and Huambo to revise their pre-service curricula to reflect: 1) the most pressing health needs of the community served, 2) the daily responsibilities of the health care professionals, and 3) the availability of diagnostic tools, drugs, and equipment in the settings in which students will work upon graduation. Due to the pressing need to scale up prevention and ART in Angola, ITECH's pre-service strengthening largely focuses on integrating up-to- date educational content on HIV and AIDS, so all categories of health care workers are better equipped to deliver HIV services.
With FY 2010 and prior year funding, ITECH will assist the MOE with the following activities:
• Convening and facilitating stakeholders in strategic planning for pre-service reform;
• Assessing the skill and knowledge needs of health care professionals in their local service contexts;
• Assessing the capacity of schools to prepare students with necessary skills and knowledge.
• Assessing the clinical content and teaching methods of existing curricula;
• Rewriting health care curricula to integrate evidence-based content, including learning objectives for curricula and competencies for graduates;

• Developing supporting materials, including syllabi, lesson plans, and reference manuals; • Mentoring and building capacity in faculty and other stakeholders in new clinical content, teaching methods, curriculum design, and monitoring and evaluation; and • Evaluating educational outcomes.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11981	**Mechanism Name: MOH/National Blood Center**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Mohammed Abdullahi Wase Specialist Hospital	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 700,000	
Funding Source	**Funding Amount**
GHCS (State)	700,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The MOH is the governmental body responsible for blood safety in Angola. Within the MOH, the National Blood Center (NBC) is responsible for developing national policies and guidelines for the delivery and implementation of blood safety interventions. The NBC is the only official national safe blood service provider of the GRA. Supporting the NBC is consistent with the Millennium Development Goals and the national mandate to strengthen the central system for sustainable practices in blood safety.

The MOH/NBC is currently working with the USG, the GFATM the private sector, and Safe Blood for Africa to train blood service staff at the provincial level as well as medical personnel in the proper use of blood products, mobilizing voluntary non remunerated blood donation (VNRBD), strengthening information systems, and exploring commitments for site renovations. With this collaboration in place, the

MOH/NBC is positioned to use these funds to expand efforts to ensure an adequate supply of safe blood for transfusion through VNRBD.

The USG with the GRA will also develop and implement a project-specific monitoring and evaluation plan by drawing on national and USG requirements and tools, including strategic-information guidance provided by the Office of the U.S. Global AIDS Coordinator and WHO. Furthermore, the USG will support development and implementation of a sustainability plan that includes advocacy with the GRA for increased commitment to national blood safety efforts.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	140,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11981**
Mechanism Name:	**MOH/National Blood Center**
Prime Partner Name:	**Mohammed Abdullahi Wase Specialist Hospital**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	700,000	

Narrative:

FY 10 funds are designated for capacity building and infrastructure development of NBC. The NBC will continue to implement the national screening strategy for all donated blood and blood products, using the most appropriate and effective tests, and adhering to good laboratory practices. Funding will be used to:
• Develop a national blood safety infrastructure plan to ensure coverage for the collection, transport, storage and distribution of blood that meets the national needs;
• Reinforce appropriate use of blood and blood components;
• Expand the volunteer blood donor base through improved donor mobilization, recruitment, retention, and communication strategies;
• Implement and maintain an information management system;

• Strengthen and sustain a donor notification program to increase the proportion of blood donors with HIV-reactive results referred to appropriate counseling, confirmatory testing, care and/or treatment; • Support human capacity development in blood centers; • Build partnerships with other blood safety stakeholders; • Ensure harmonization of blood safety activities; • Develop an annual work plan to guide program activities and achieve planned outcomes; • Develop and link indicators to each activity to assess program outcomes; • Review and adjust program activities based on monitoring information; • Evaluate clinical outcomes (e.g., hemo-vigilance data) to assess the impact of the program; • Develop protocols and obtain relevant clearances from CDC Associate Director of Science prior to implementing data evaluation projects; • Develop a supervision plan to ensure ongoing quality assurance of all program activities; and • Conduct strategic planning for the sustainability of blood safety services.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11982	**Mechanism Name: CDC Technical Assistance**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: USG Core
Prime Partner Name: CDC National Prevention Information Network	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 605,000	
Funding Source	**Funding Amount**
GHCS (State)	605,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Narrative Overview

Currently, CDC provides direct technical assistance in the implementation of host government program activities. In addition, CDC also brings experts from headquarters and other countries to assist in a variety of areas.

Laboratory

A strong national public-health laboratory network is the cornerstone of a strong response to HIV/AIDS. The laboratory advisor and other experts are building capacity for high-quality laboratory services to assist with the rapid expansion of HIV treatment, and the accompanying need for HIV diagnosis and associated care. They have provided training and on going support for the following:
• HIV diagnostics and HIV incidence testing;
• Hematology, chemistry, and CD4 testing;
• TB/opportunistic infection (OI) testing;
• Antiretroviral therapy resistance testing;
• Dried blood spot polymerase chain reaction (DBS-PCR) for early infant diagnosis;
• Viral load monitoring; and
• Quality control and quality assurance of laboratories and testing activities.

This support will continue in FY10.

SI/Monitoring and Evaluation and Surveillance
The capacity of resource-constrained nations to strategically collect and use information for program accountability and improvement is critical for sustainability. CDC experts collaborate with the GRA to build surveillance capacity and ensure evidence-based programming.
To better understand the relationships among population, HIV prevalence, and existing services, CDC staff members:

• Build in-country capacity to design, implement, and evaluate HIV/AIDS-related surveillance systems and surveys; and assist and train on how to analyze, disseminate, and use HIV/AIDS data;
• Develop tools, guidelines, recommendations, and policies to translate research for improved planning and program implementation; and
• Evaluate and implement novel approaches for conducting surveillance and surveys.

To assist countries to assess and improve HIV/AIDS programs through effective monitoring and evaluation (M&E) at the local, regional, and national levels, CDC staff members:
• Increase country capacity to monitor, evaluate, and report on process, outcomes, and impact of

HIV/AIDS programs;
• Help to lead public-health evaluations, that ensure interventions are scientifically sound and delivered as effectively and efficiently as possible; and
• Provide technical assistance on the development and implementation of planning and reporting systems.

HSS/FELTP

FELTP is tailored to strengthen public health capacity in accordance with Angola's culture, national priorities, established relationships, and existing public health infrastructure. In addition, to establish an FELTP, CDC will provide MOH with an in-country resident advisor to help guide training and technical assistance.

The CDC Resident Advisor (RA) to the Field Epidemiology and Laboratory Training Program (FELTP) supports the Angolan Ministry of Health (MOH) by providing technical assistance in the planning and implementation of an FELTP to meet national epidemiologic needs. The major goals of the FELTP are to 1) provide essential epidemiologic services to the MOH; 2) train teams of medical epidemiologists and public health laboratorians within the MOH; and 3) strengthen the public health system's capacity and infrastructure of MOH. The RA will collaborate with a national counterpart, the FELTP Director, in conducting day-to-day and strategic activities of the FELTP.

CDC's roles and responsibilities for A-FELTP are as follows:
• Assist with securing funds for the program and its activities during the first five years;
• Provide technical assistance and support to program, including during field assignments;
• Supply reference, training and teaching materials;
• Facilitate exchange of experiences from other country Field Epidemiology Training Programs (FETPs);
• Participate in overall monitoring and evaluation of trainees; and
• Serve on the A-FELTP steering committee.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11982**
Mechanism Name:	**CDC Technical Assistance**
Prime Partner Name:	**CDC National Prevention Information Network**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	500,000	

Narrative:

In 2010, CDC will:
• Finalize, along with Angola MOH and other partners, an integrated and sustainable training plan to build evidence-based public health capacity;
• Finalize curriculum and facilitate courses in epidemiology, surveillance, outbreak investigation, biostatistics, among others, along with local faculty, MOH staff, and other guest lecturers;
• Work with MOH counterparts to finalize guidelines trainee selection;
• Work with MOH counterparts to finalize field site guidelines and obtain site commitments for participation;
• Provide supervision, mentoring, and support to program director or other designated local point person as they assume leadership responsibility and overall program management responsibility; and
• Provide TA for faculty.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	105,000	

Narrative:

With PFIP funding, CDC will provide technical assistance to implement the following laboratory activities in FY 2010:
• Training will be provided to the molecular biology laboratory technicians from both the Public Health Institute and the National AIDS Institute on HIV sequencing and genotyping. The country currently has one national reference laboratory that is equipped with the required equipment for sequencing protocols; however technical assistance is necessary to build the country's capacity to implement ARV resistance testing and other diagnostic techniques for HIV and Opportunistic infections.
• Invitational travel for Laboratory technicians to attend CDC sponsored meetings and regional conferences will be supported as part of the capacity- building and soutn to south experience- sharing efforts.
• "On-the-job" training for laboratory technicians at the provincial level will be provided in Serology, CD4,

TB microscopy, Hematology and Biochemistry techniques . Laboratory technicians who successfully complete the training will become trainers-of-trainers and begin training lab technicians at the municipal level laboratories. Technical assistance will be provided to develop a laboratory certification process to achieve sustainable quality improvement systems.

• Angola is piloting its Early Infant Diagnosis (EID) Program at 4 PMTCT sites in Luanda. CDC is providing technical assistance for Dry Blood Spot sample collection and laboratory molecular PCR assay implementation and is part of the technical group led by the National AIDS Institute. The Angolan EID pilotis is leveraged and coordinated with the Clinton Foundation that is supporting the country with sample collection consumables and reagents during the first phase of program expansion. CDC plans to support the expansion of EID with training and supervisory visits for sample collection, storage and transportation; as well as developing registration and collection procedures in Cunene and other designated provinces. Capacity building efforts at the reference laboratory will include assessment of the quality of sample collected for testing, storage and transportation procedures, and documentation and recording challenges.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11983	**Mechanism Name: Capacity Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Capacity Project	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 250,000	
Funding Source	**Funding Amount**
GHCS (State)	250,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY10, five new medical schools will open along with an unknown number of new training programs will

be implemented for new healthcare workers. As a result of this expansion, the number of health care workers will increase substantially in the next few years. Despite the chronic shortage of health care workers in Angola, specifically doctors, midwives, laboratory technicians and pharmacists, the current health care infrastructure is both unable and ill-equipped to absorb such rapid expansion of the healthcare workforce. In order to increase the absorbability of this large influx of new healthcare workers into the current system while managing existing workers, it is imperative that the USG provide technical assistance (TA) to support the implementation of managerial systems and build the capacity in the hiring, distribution, and retention of health care workers. The Capacity Project will provide support to the MoH and INLS with a Human Resources Assessment, the development of a Human Resources Strategic Plan, and the establishment of a Human Resources Information System.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	25,000
Human Resources for Health	225,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11983**		
Mechanism Name:	**Capacity Project**		
Prime Partner Name:	**Capacity Project**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	250,000	
Narrative:			
In FY 2010, the Capacity Project will first be implemented in the priority areas of border districts such as Luanda and Cunene to ensure that a well functioning management system is in place so that resources can be distributed equitably in the most effective manner. The project will then potentially be expanded to other regions of the country. Furthermore, it is essential that routine performance evaluation for healthcare workers are established and the appropriate in-service training can be offered to these newly trained healthcare workers once they enter the workforce in order to effectively monitor and improve the			

quality of the services they provide for their patients. The USG will support the MOH's effort to improve the retention rate of healthcare workers in the country and assist the government is using the Human Resources Information System, once it is established, to efficiency allocate and train healthcare workers according to needs.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11984	**Mechanism Name: NSP PEN**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In 2006, the Institute for fighting HIV/AIDS in Angola (INLS) developed her second National Strategic Plan (NSP) for the 2006-2010 period. This plan has been used since 2006 to implement the Angolan HIV/AIDS strategy in the country and was the basis for two Global Fund proposals in 2008 and 2009. Since 2010 is the last year of implementation for the NSP 2006-2010, the INLS will develop a new plan during the period of February until April 2010. The new plan will be based on the revision of the UNGASS report, the results of the latest ANC surveillance study and consultations with civil society and other stakeholders in the fight against HIV/AIDS.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	Redacted

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	11984		
Mechanism Name:	NSP PEN		
Prime Partner Name:	TBD		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	Redacted	Redacted
Narrative:			
The INLS requested USG to give technical assistance during the final phase of the development of the new NSP, in particular for the costing of the plan, during the revision process in the month March/April.			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11985	**Mechanism Name: APHL (Lab)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Association of Public Health Laboratories	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 355,000	
Funding Source	**Funding Amount**
GHCS (State)	355,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

With the support of PEPFAR, the INSP is currently developing a National Laboratory Network Strategic Plan. An assessment of the existing laboratory structure, its capacity, operational status and constraints from the municipal to the national levels is urgent to implement and strengthen this network.

The USG is funding APHL to implement the following activities in FY 2010:

• Assessment of the Laboratory capacity and the development of a National Laboratory Network Strategic Plan: Two international consultants will conduct an extensive assessment of the provincial hospitals and one municipal hospital in the 9 provinces with PEPFAR lab activities. The assessment will include different areas such as technical capacity in terms of technicians, equipment and physical conditions as well as procurement and logistic capacities. Based on findings and recommendations resulting from the assessment, a consultant will work with the Public Health Institute, the MoH, and CDC to develop the National Laboratory Network Strategic Plan which will guide country activities for the next five years regarding the laboratory network objectives.

• National Advisory Technical Committee will be supported: The USG will support the creation of a committee to advocate, support, and coordinate laboratory technicians and clinicians. This national committee will follow and guide the network implementation strategic plan and function with support of the provincial focal points for the Laboratory Network.

• Establish Quality Management Systems for Accreditation: A Quality Manager (national) will be supported to work at the Public Health Institute's national Reference Laboratory. This Quality Manager will enroll in an international Quality Training Program and will visit certified laboratories and review and learn about their quality systems. The quality manager will work with a mentor to design a quality program for the Public Health Institute and return to Angola for implementation. South to south experience sharing with Mozambique, where laboratory network implementation has begun, will be supported, beginning with a technical exchange trip of an Angolan team to Mozambique to visit and learn about their laboratory network.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	142,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	11985		
Mechanism Name:	APHL (Lab)		
Prime Partner Name:	Association of Public Health Laboratories		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HLAB	355,000	

Narrative:

Specific funded activities will include:

• Conduct provincial lab assessments, including procurement and logistics, capacities to sustain the techniques, maintenance of equipment, quality systems in place, quality control of techniques, management, and others. The comparative assessment of these provinces will provide a current overview of the quality and functionality of the lab situation in Angola and generate recommendations on the required next steps to develop an efficient and sustainable network of laboratories. The budget also includes funding for technical assistance for the development of the national laboratory network strategic plan, based on the results of the assessment.

• Support technical assistance to develop appropriate Terms of Reference and selection processes for the national advisory technical committee. To implement the Laboratory Network according to the laboratory strategic plan, a Laboratory Network Implementation Plan will be developed detailing the tasks required to implement each activity to accomplish each objective and target proposed in the strategic plan. The implementation plan will be generated by a consultant coordinating with the Public Health Institute and identified laboratory partners. Technical assistance will be provided to the country to support activities for the implementation of the network, as per requested by the country such as reinforcement of technical capacities for management, logistics of the network, communication, etc.

• Support the activities of the lab quality manger and mentor who will have regular visits to Angola to follow up on implementation, provide technical assistance and guidance to the Quality Manager and the Public Health Institute. This specialized laboratory professional will play a key role in assisting implementation of quality systems at other network laboratories. In addition, support for improving the lab quality system and maintenance contracts for key equipment at the reference lab.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11986	Mechanism Name: BSS+
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Considering the well documented importance of monitoring the epidemic and the behavior of most-at-risk populations (MARPs) for HIV, the Instituto Nacional de Luta contra a SIDA (INLS) has requested assistance in conducting behavioral and serologic surveillance (BSS) in Angola with MARPs. These BSS will include biological markers for syphilis and HIV with an in-depth, interviewer-administered questionnaire. The results of the BSS will constitute a baseline for a second generation behavioral surveillance system to be implemented in country. This baseline will provide program managers and planners with information that contributes to HIV prevention and care programs targeting these aforementioned vulnerable populations; as well as provide valuable insights regarding the prevalence of HIV and syphilis in these populations. The first priority cluster for BSS included young women engaged in transactional sex in the border region, men who have sex with men (MSM), and truckers. The INLS has identified the next priority cluster of BSS should target uniformed forces (police and border authorities), miners and prisoners.

The preliminary field investigation (formative research) and protocol development phases of the study were conducted in FY2009. Since that time, considerable progress has been made on the implementation of the young women's BSS. The protocol has been approved by all relevant parties and data collection scheduled for March 2010. A contract has been awarded for the MSM BSS and the protocol is under review. The solicitation for the trucker BSS is being developed. These activities will be completed with prior year funding.

During 2010, the USG will award contracts to begin the next cluster of BSS, specifically police and

boarder authorities and miners. These solicitations are being developed.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	Redacted

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11986**		
Mechanism Name:	**BSS+**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	Redacted	Redacted

Narrative:

Tulane University will complete the following activities during FY2010 with prior year funding:
Young women engaged in transactional sex on the Angola-Namibia border region of Cunene
1. Completion of data collection with prior funding
2. Data analysis and dissemination of results

Men who have sex with men (MSM)
1. Obtain approval of relevant IRBs or other appropriate body
2. Survey implementation/data collection
3. Data analysis and dissemination

An organization TBD will begin the following activities during FY2010 with prior year funding:
Truckers
1. Obtain approval of relevant IRBs or other appropriate body
2. Survey implementation/date collection
3. Data analysis and dissemination

With FY10 funding, a TBD organization will begin the following activities during FY2010: Uniformed Forces (police and border authorities) 1. Obtain approval of relevant IRBs or other appropriate body 2. Survey implementation/data collection 3. Data analysis and dissemination Miners 1. Obtain approval of relevant IRBs or other appropriate body 2. Survey implementation/data collection 3. Data analysis and dissemination

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11987	**Mechanism Name: FELTP MOH**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Mohammed Abdullahi Wase Specialist Hospital	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 150,000	
Funding Source	**Funding Amount**
GHCS (State)	150,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Human resources represent a major challenge in terms of both quantity and capacity of the healthcare delivery system to address Angola's public health needs. Angola currently has one physician, fourteen nurses, one pharmacist and one laboratory technician per 10,000 people. These statistics illuminate the critical shortage of skilled public health workers, particularly field epidemiologists and laboratory

managers, with the capacity to respond to the increasing public health needs in the Republic of Angola. This shortage of qualified and capable health care workers poses a major challenge for healthcare delivery. The Angola Field Epidemiology and Laboratory Training Program (A-FELTP) is a collaborative effort of the Angola Ministry of (MoH), University Agostinho Neto, the African Field Epidemiology Network (AFENET), and PEPFAR to address human resource issues regarding qualified epidemiology and lab personnel.

The shortage of qualified health care workers poses a major challenge for quality and sustainable health care delivery. Implementation of the Field Epidemiology and Laboratory Training Program (FELTP) will 1)enhance retention of health care providers through specialization opportunities; 2) increase the number of qualified professionally trained health care workers through short term trainings (60 annually in field-based applied epidemiology, laboratory management and public health practice training); 3)strengthening the capacity of health and training institutions to meet accreditation standards; 4) contribute to the development of specific evidence based pre-service curricula; 5) in collaboration with the Avian Influenza program, through a staged process, 6-12 residents will be trained annually to earn a specialization or masters degree in public health; 6) develop curriculum for training of trainers and terms of reference for the lab trainers to build human resources to support expansion and decentralization of the laboratory network. Partnerships will be sought with the private sector to support students enrolled in the program. The program will be initiated in Luanda; other provincial universities that are now being stood up could receive training support initially via distant learning technology sponsored by the World Bank. Technical assistance will be provided to explore twinning opportunities with compatible universities to strengthen and adopt standardized, pre-service competency-based education driven by evidence of need.
The USG support for the A-FELTP, Angolan Field Epidemiology and Laboratory Training Program, at UAN is consistent with the Government of Angola (GRA's) National Strategic Plan to strengthen a cadre of public health professionals to adequately respond to the national initiative to combat HIV/AIDS. A Memorandum of Understanding has been executed among the Ministry of Health, UAN and AFENET to establish the A-FELTP.

The roles and responsibilities of MOH are as follows:
• Serve as a major stakeholder and leader to support the training program throughout the project lifecycle, providing guidance and leadership for the A-FELTP
• Sponsor the A-FELTP, essentially supporting, owning and managing the A-FELTP
• Recruit or assign health professionals (preferably Epidemiologists or Public Health physicians) to operate in the positions of Epidemiology Director and Laboratory Director to coordinate and manage the program
• Provide access to national surveillance data and grant authorization to investigate and respond to public

health outbreaks and other emergencies in a timely fashion
• Develop and supply a list of competency domains that should be addressed by the training curriculum
• Coordinate and oversee the screening of candidates for the A-FELTP
• Sponsor MOH trainees (pays full salary throughout the period of training)
• Support and facilitate field practicum of the trainees
• Grant a specialization certification upon successful completion
• In collaboration with other relevant stakeholders, develop and facilitate the career ladder/career structure of trainees, upon completion of FELTP, allowing for possible promotion and salary increase based on candidate's qualifications in an effort to retain highly qualified field epidemiologists and public health laboratory technicians in government positions.
• Provide MOH sites, at Central, Provincial and/or District levels for placement of the participants during the training period
• Be the main beneficiary and end user of the product/graduates of the course
• Provide expertise in co-supervision of candidates during field attachment in partnership with CDC-Angola and ANU.
• Chairs and convenes the steering committee.
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Cross-Cutting Budget Attribution(s)

Human Resources for Health	120,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11987**
Mechanism Name:	**FELTP MOH**
Prime Partner Name:	**Mohammed Abdullahi Wase Specialist Hospital**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	150,000	

Narrative:

The USG will fund the MOH to achieve the following activities: • Develop and implement, along with other partners, an integrated and sustainable training plan to build evidence-based public health capacity. • Develop, along with other partners, curriculum and facilitate courses in epidemiology, surveillance, outbreak investigation, biostatistics, among others, along with local faculty, MOH staff, and other guest lecturers. • Work with counterparts to develop guidelines for trainee selection and select first cohort of trainees • Work with counterparts to develop field site guidelines and obtain site commitments for participation. • Designate a program director or other local focal person to be mentored to assume leadership responsibility and overall program management responsibility. • Strengthen affiliations with international organizations, the Africa Field Epidemiology Network (AFENET) and Training in Epidemiology and Public Health Interventions Network, an umbrella organization of applied epidemiology and laboratory programs in other countries, and • Enhance communications and networking of public health practitioners and researchers in the country and throughout the region. • Enhance linkages between public health epidemiology and laboratories. • Register up to 30 participants for each of two short courses. • Register the first cohort students for the 2 year program.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11988	**Mechanism Name: FELTP MOE**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Moepathutse Children's Centre	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 150,000	
Funding Source	**Funding Amount**
GHCS (State)	150,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Narrative Overview

Human resources represent a major challenge in terms of both quantity and capacity of the healthcare delivery system to address Angola's public health needs. Angola currently has one physician, fourteen nurses, one pharmacist and one laboratory technician per 10,000 people. These statistics illuminate the critical shortage of skilled public health workers, particularly field epidemiologists and laboratory managers, with the capacity to respond to the increasing public health needs in the Republic of Angola. This shortage of qualified and capable health care workers poses a major challenge for healthcare delivery. The Angola Field Epidemiology and Laboratory Training Program (A-FELTP) is a collaborative effort of the Angola Ministry of (MoH), University Agostinho Neto (UAN), the African Field Epidemiology Network (AFENET), and PEPFAR to address human resource issues regarding qualified epidemiology and lab personnel. Currently, UAN is the only public medical academic institution with the capacity to develop a highly skilled public health workforce, equipped to respond to the dire public health needs in Angola. GRA has given UAN the legal authority to coordinate and provide higher public health education and medical studies. As a result, this is the only eligible applicant for this funding opportunity and the only applicant to serve as the host university for the A-FELTP

Implementation of the Field Epidemiology and Laboratory Training Program (FELTP) will 1)enhance retention of health care providers through specialization opportunities; 2) increase the number of qualified professionally trained health care workers through short term trainings (60 annually in field-based applied epidemiology, laboratory management and public health practice training); 3)strengthen the capacity of health and training institutions to meet accreditation standards; 4) contribute to the development of specific evidence based pre-service curricula; 5) in collaboration with the Avian Influenza program, through a staged process, 6-12 residents will be trained annually to earn a specialization or masters degree in public health; 6) develop curriculum for training of trainers and terms of reference for the lab trainers to build human resources to support expansion and decentralization of the laboratory network. The program will be initiated in Luanda; other provincial universities that are now being stood up could receive training support initially via distant learning technology sponsored by the World Bank. Technical assistance will be provided to explore twinning opportunities with compatible universities to strengthen and adopt standardized, pre-service competency-based education driven by evidence of need.
The USG support for the A-FELTP at UAN is consistent with the Government of Angola (GRA's) National Strategic Plan to strengthen a cadre of public health professionals to adequately respond to the national initiative to combat HIV/AIDS. A Memorandum of Understanding has been executed among the Ministry of Health, UAN and AFENET to establish the A-FELTP.

The roles and responsibilities of MOE/UAN are as follows:
• Offer the degree certificates upon successful completion of the course;
• Support the A-FELTP throughout the development process;
• Assist in finalizing training curriculum ;
• Obtain approval of the A-FELTP curriculum;
• Serve as the host for the Public Health Laboratory Residents and Field Epidemiology Residents;
• Award a MPH in Laboratory Epidemiology and Management, Field Veterinary Epidemiology or Field Epidemiology upon satisfactory completion of the program;
• Provide academic supervision during field attachment and dissertation writing; and
• Provide time to residents to conduct outbreak investigation during the training period when requested by MOH.
• Participate on the A-FELTP steering committee.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	120,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11988**
Mechanism Name:	**FELTP MOE**
Prime Partner Name:	**Moepathutse Children's Centre**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	150,000	

Narrative:

The USG will fund the MOE/UAN to achieve the following activities:
• Develop and implement, along with other partners, an integrated and sustainable training plan to build evidence-based public health capacity.
• Develop, along with other partners, curriculum and facilitate courses in epidemiology, surveillance,

outbreak investigation, biostatistics, among others, along with local faculty, MOH staff, and other guest lecturers. • Work with counterparts to develop guidelines for trainee selection and select first cohort of trainees • Work with counterparts to develop field site guidelines and obtain site commitments for participation. • Designate a faculty focal person to assume leadership responsibility for university participation. • Strengthen affiliations with international organizations, the Africa Field Epidemiology Network (AFENET) and Training in Epidemiology and Public Health Interventions Network, an umbrella organization of applied epidemiology and laboratory programs in other countries, and • Enhance communications and networking of public health practitioners and researchers in the country and throughout the region. • Work with counterparts to identify and train faculty. • Develop and appropriate academic environment for trainees (classrooms, internet access, and other logistics). • Conduct two short courses for various public health managers • Enroll the first cohort of the two-year program

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11989	**Mechanism Name: GENDER VIOLENCE**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The challenge of HIV/AIDS and gender specific programming in Angola is the nascent and limited capability of civil society, due mainly to the civil war, which decimated this section of society. The issues around capacity affect all areas and make program implementation slow and challenging in general and particularly in terms of gender which is a new concept. The term "gender" is typically equated with women, if considered and/or understood at all. In Angola there is a para-statal OMA, which is the voice for women and gender issues. However, this organization has political interests that do not always address the health needs of women and men in Angola.

Another challenge to programming in Angola is the vast cultural and socioeconomic differences among provinces. There are different religions and cultural factors that influence important aspects of HIV/AIDS prevention, care and treatment for men and women. People report varying rates of male circumcision, risky sexual practices, self-identification as a Commercial Sex Worker (CSW), education and literacy levels and access to HIV/AIDS information. These variables need to be better understood and considered through a gender lens in the design and implementation of programs.

A law against gender-based violence (GBV) has been drafted, but is stalled and yet to be passed in the Assembly. While the development of a law to protect against GBV is admirable, the entire process is slow and does not appear to be a top priority for the government. Once this law is actually enacted, there will be a great deal of work to be done to ensure proper and effective implementation of the law.

Currently, when domestic violence occurs, it is difficult to file a complaint about abuse or sexual violence. Few forensic scientists and social workers trained in GBV exist in the country and charges are often not taken seriously by police. This makes it difficult to build a credible case (especially in cases of sexual abuse/rape). Also there is a lack of referral systems to clinical settings, counseling, and little in the way of support services for GBV either government or civil society. Because of these barriers, women are often unprotected and trapped in abusive relationships and continue to be victims of GBV occurrences with no support and recourse.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	Redacted
Human Resources for Health	Redacted

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11989**		
Mechanism Name:	**GENDER VIOLENCE**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	Redacted	Redacted

Narrative:

this TBD will fall into the OHSS budget code, as it is high level policy work to support the implementation of the new law on GBV. This TBD will build, create and support critical linkages to, and between, gender support services and the legal system.
A critical component will be to build the capacity of key stakeholders, especially police. Bringing awareness of the law and its interpretation is critical to the effective implementation of the law. Linkages and systems need to be identified, strengthened and perhaps created to support its implementation. An assessment of the current gender issues and existing gender-based interventions will be conducted in the country when the law against GBV is passed by the Angolan legislators.
This project will coordinate efforts with prevention efforts. A key element will be to influence and help design a national BCC strategy, with emphasis on gender issues. This activity will also create and strengthen linkages with other prevention activities to improve how the government and civil society address gender issues, specific to the GBV legislation.
Implementation of this activity requires a strengthened partnership with the GRA. MINFAMU will be tasked with implementation of the legislation. However, other relevant ministries and stakeholders will also play important roles and the USG will be working together with these key stakeholders to implement this policy. Collaboration is already established between UNDP and MINFAMU along these linkages.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11990	**Mechanism Name: TB coinfection**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Charles Drew University	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 150,000	
Funding Source	**Funding Amount**
GHCS (State)	150,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Narrative Overview

Charles Drew University of Medicine and Science in Los Angeles, California (CDU) is committed to improving the health of the under-served populations of the world. CDU has been partnering with the Angolan Armed Forces on a prevention program since 2001, and has been expanding its relationships with Angolan agencies ever since.

In the context of growing HIV/TB co-infection in Angola, Africa, the proposed project focuses on developing Angolan institutional capacity for a coordinated and long-term response to these co-occurring epidemics. Through technical assistance provided by Charles Drew University to the Angolan National Programs for HIV and TB and to the medical universities of Agostinho Neto and Jean Piaget, this project will design protocols and training curricula to improve surveillance, diagnostics, and treatment of HIV/TB co-infection. At the conclusion of this project, the main institutions charged with the coordinated HIV/TB response will be in possession of the protocols that define the roles, obligations and methodologies to be followed by health providers and other stakeholders, as well as training materials to prepare health providers to diagnose and treat HIV/TB co-infection.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11990**		
Mechanism Name:	**TB coinfection**		
Prime Partner Name:	**Charles Drew University**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HVTB	150,000	
Narrative:			
With COP 10 funding CDU will provide technical assistance to the National program for HIV and TB to design protocols and training curricula to improve surveillance, diagnostics, and treatment of HIV/TB co-infection. CDU will also continue facilitating the national TB advisory group.			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11991	**Mechanism Name: AIDS Indicators Survey**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Macro International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHCS (State)	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Implementing Mechanism Narrative:

The level of HIV prevalence in Angola has been estimated to be 2.1% for 2008 (INLS, Annual HIV surveillance Report) and 2.5 for 2005 (UNAIDS 2005 ANC data.) These results came from relatively small datasets and there is consensus that HIV/AIDS program in Angola could immensely benefit from well grounded HIV prevalence estimates. In order to meet this pressing need for reliable estimates, the Ministry of Health has signed a contract with a local firm –COSEP—, using funds from Round 6 GFATM, to conduct a Conduct Attitudes and Practices (CAP) Survey and AIDS Indicators Survey (AIS) with sampling representativeness at regional level. To ensure the highest level of performance in the design and implementation of this survey, the MOH has requested the recruitment of Macro International, Inc., which has extensive experience in designing and implementing population-based surveys, for technical assistance.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	50,000

Key Issues

Military Population

Budget Code Information

Mechanism ID:	**11991**		
Mechanism Name:	**AIDS Indicators Survey**		
Prime Partner Name:	**Macro International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	100,000	
Narrative:			
In FY 2010, Marco will be in charge of providing technical assistance to COSEP in the areas of survey research, statistical applications and analysis for CAP and AIS. Major focuses of the PFIP prevention strategy are the provinces of Luanda and Cunene. For this reason, it has been considered strategic to use the opportunity of the CAP/AIS study to secure the prevalence level at the level of these two provinces for FY 2010. In order to achieve this, there is the requirement to increase the sample size both in Luanda and Cunene, implying an extension of the field work (translating to an increased number of			

respondents contacted) and the corresponding logistics requirements. PEPFAR has made the decision to join the venture of this CAP/AID study by adding $200,000 to the MOH contract with Macro International to assist them in producing reliable HIV prevalence rates for both the provinces of Luanda and Cunene. The CAP/AID studies have begun their initial planning and implementing process and the MOH expects that field work will conclude by June-July 2010 and preliminary results will be available before the end of the year.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11992	**Mechanism Name: Jango Juvenil Assessment**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Population Services International (PSI) and World Learning operate five Jango Juvenil centers throughout Angola. They are located in the provinces of Huambo, Cabinda, Cunene, Luanda and Huila. Jango operating funds have been provided by USAID/Angola as well as Banco Fomento de Angola (BFA) as part of a public private partnership. These centers started in 2002/2003. Within each project site the activities are run by different local NGOs. PSI provides BCC materials and trainings for the staff at these sites. During FY 09 the granting of the Jangos was transferred from PSI to World Learning Angola. Hence, World Learning is now responsible for capacity building of Jangos NGO staff in management, finance, and monitoring and evaluation.

The specific activities of each Jango vary depending on the local context within the provinces and municipalities in which they implement. However, a typical Jango offers classes in sewing, bakery and English to youth 10-18 years of age. HIV/AIDS messages are integrated into each class. It is common for the classes to begin with a 5-30 minute discussion on HIV/AIDS prevention. The topics discussed can range from basic facts to sexuality to condoms. They use a comprehensive approach to prevention and discuss ABC. In classes, such as English or drama, where the opportunity presents itself, HIV/AIDS messaging is integrated into class discussion. It is not uncommon for English class debates to center on HIV/AIDS prevention messages. The Jango also holds other activities for youth including film screenings, sports, and community outreach programs such as Community Theater performances, health fairs and BCC messaging targeted at street youth.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	Redacted

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11992**
Mechanism Name:	**Jango Juvenil Assessment**
Prime Partner Name:	**TBD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

The Jango Juvenil project started in 2006 and has never been evaluated by an external party. Due to the expansion of the PEPFAR program in Angola a resulting policy shift from PEPFAR II, the Jango Juvenil project will receive more attention as a viable option for the implementation of comprehensive community based prevention programming. Although the Jangos have already undertaken some community-based approaches, it is hoped that they can be used as a vector in HIV/AIDS programming to build linkages among important community actors such as schools, law enforcement, and parents. The Jangos will also need to build relationships and integrate their activities with those of the local city administration,

MINJUD, and the ministry of youth and sports. While the Jango Juvenil project is being transitioned and further developed, it is pertinent that both the Jangos and their local implementers undergo an external evaluation. The SOW for the evaluation will also include a more broad assessment of youth activities on a national level. In addition, a series of recommendations will be requirement within the SOW to ensure that future implementing partners are able to develop the Jango Juvenil project in a way that ensures sustainability, increased collaboration and coordination with the GRA and other stakeholders and greater integration with the local communities in which they are located.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11993	**Mechanism Name: MAPPING/GIS AED USAID**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Academy for Educational Development	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 150,000	
Funding Source	**Funding Amount**
GHCS (USAID)	150,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The GIS mapping project with the implementing partner AED was initiated at the end of FY 09. The long-term goal of the project is to improve the response to the HIV/AIDs epidemic in Angola. The short-term objective of GIS mapping is to improve the framework for the USG, GRA, and other stakeholders to deploy resources to areas where there is the greatest need. Angola needs a coordinated, expanded response, and, as a first step, critical gaps in services, information, data, and location of services must be addressed. In keeping with these objectives, AED is creating maps of Angola that will illustrate the type

of facilities, the locations, and the types of services offered at the facilities. HIV services being analyzed include Voluntary Counseling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT), Lab capability for CD4, and Tuberculosis testing and treatment.
The project is being implemented in two phases. The first phase includes collecting data and coordinating with other implementing partners, other stakeholders and the GRA to create a set of maps to be delivered in the second quarter of FY 10. The collection of primary data will begin in the second phase. The maps will continually be updated with incoming data from both collected by the implementers and other studies, e.g., AIS, PLACE, BSS etc., expected to be conducted during the fiscal year.
Within the first month of implementation, FY 09, the first set of draft maps were produced, detailing the location of facilities and the types of services offered for five provinces. AED has already trained three staff from the Ministry of Health in GIS analysis and map making.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	15,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11993**
Mechanism Name:	**MAPPING/GIS AED USAID**
Prime Partner Name:	**Academy for Educational Development**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	150,000	

Narrative:

AED will, initially, be designing a pilot survey of Bengo Province, which is planned for February 2010. GIS data will facilitate a visual analysis and help prioritize activities and resources in combating HIV/AIDS. The data collected to date is from secondary sources, such as the Ministry of Health. A national effort will be rolled out on the basis of the experiences in the first pilot province and in consideration of time and funds required.

The following sectors will be mapped under this proposed activity: a) Transport (road) networks, specifically showing the major truck transport routes and open border crossings; b) Provincial and regional hospitals and possibly municipal hospitals/clinics; c) Mining activities d) Health facilities offering Voluntary Counseling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT), Antiretroviral Therapy, and Tuberculosis testing and treatment. The data collected will also illustrate whether the facility offers health systems strengthening, enhanced reproductive health, and community outreach programs; e) Laboratories that provide CD4 and HIV/AIDS testing; f) Economic growth areas where foreign investments are concentrated; and g) Educational facilities. An important aspect of this proposed activity will be training national, provincial, and local government staff on data analysis and GIS map creation. The second layer of information collected will be demographic data related to combating the HIV/AIDS epidemic. The following data is to be gathered and mapped: a) Data on the prevalence of HIV/AIDS by province, looking at the priority target group of people between the ages of 15-24 after the results of the AIS and ANC prevalence studies are known; b) Average educational level of the population for each province; c) Prevalence of male circumcision; and d) Ethnic groups (culture/language).

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11994	**Mechanism Name: Priorities for Local AIDS Control Efforts (PLACE)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Umbrella Agreement
Prime Partner Name: Measure Evaluation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

USAID/Angola has requested MEASURE Evaluation (under the Carolina Population Center) to conduct Priorities for Local AIDS Control Efforts (PLACE) studies in Angola. The purpose of this rapid assessment is to identify geographic areas where HIV transmission is likely to be high and where prevention programs should be focused. PLACE will provide critical information including a list of venues where people meet new sexual partners, a description of characteristics of the venues and their patrons, and information to monitor youth-focused and general HIV/AIDS prevention programs at these venues, including information about sexual behavior. The study will provide quantitative data that will inform future strategic programming for PEPFAR Angola, especially HIV prevention programs, condom promotion and behavior change interventions.

An initial exploratory visit occurred in October 2009. Proposals from interested local research organizations were solicited, and all proposals were evaluated for cost, complexity, and experience. It was decided that MEASURE Evaluation-UNC will provide technical assistance to Population Services International (PSI) in Luanda, Angola to implement fieldwork for this study. To that end, MEASURE Evaluation, in concert with PSI, completed a full draft of the submission to the National Ethics Committee, including a study protocol, all draft questionnaires, and consent procedures. The first two study locations were also decided in collaboration with USAID and the National Institute for HIV/AIDS Prevention (INLS). Pending final approval from the National Ethics Committee, the first two studies will be carried out in Rocha Pinto (a neighborhood of Luanda) and in downtown Luanda before September, 2010. As an alternative, a proposal is being developed to cover the whole of Luanda.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services					39,000	39,000
ICASS					82,000	82,000
Management Meetings/Professional Developement					75,000	75,000
Non-ICASS Administrative Costs					4,000	4,000
USG Staff Salaries and Benefits				655,000	340,000	995,000
Total	**0**	**0**	**0**	**655,000**	**540,000**	**1,195,000**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount

Computers/IT Services		GHCS (USAID)		39,000
ICASS		GHCS (USAID)		82,000
Management Meetings/Professional Developement		GHCS (USAID)		75,000
Non-ICASS Administrative Costs		GHCS (USAID)		4,000

U.S. Department of Defense

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
ICASS				60,000		60,000
Management Meetings/Professional Developement				20,000		20,000
Staff Program Travel				40,000		40,000
USG Staff Salaries and Benefits				80,000		80,000
Total	**0**	**0**	**0**	**200,000**	**0**	**200,000**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHCS (State)		60,000
Management Meetings/Professional Developement		GHCS (State)		20,000

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Capital Security Cost Sharing			31,000	45,000		76,000
Computers/IT Services			10,000	175,000		185,000
ICASS			430,000			430,000
Institutional Contractors				170,000		170,000
Management Meetings/Professional Developement			141,000			141,000
Non-ICASS Administrative Costs			109,000			109,000
Staff Program Travel			303,000			303,000
USG Staff Salaries and Benefits			1,976,000	100,000		2,076,000
Total	**0**	**0**	**3,000,000**	**490,000**	**0**	**3,490,000**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GAP		31,000
Capital Security Cost Sharing		GHCS (State)		45,000

Computers/IT Services		GAP		10,000
Computers/IT Services		GHCS (State)		175,000
ICASS		GAP		430,000
Management Meetings/Professional Developement		GAP		141,000
Non-ICASS Administrative Costs		GAP		109,000