UNITED NATIONS DEVELOPMENT PROGRAMME

PROJECT DOCUMENT
[ANGOLA]

UNITED NATIONS DEVELOPMENT PROGRAMME

PROJECT DOCUMENT
[ANGOLA]

Empowered lives. Resilient nations.

Project Title: Strengthening the national response of HIV/AIDS
Project Number: AGO-H-UNDP
Implementing Partner: National Institute to fight HIV/AIDS
Start Date: July 1, 2016 **End Date:** June 30, 2018 **PAC Meeting date:** 01/07/2016

Brief Description
The Angolan national stakeholders in fight against HIV (INLS, WHO, civil society etc), through the national coordinating mechanism CCM applied for funding of an integrated HIV programme to GF in October 2015. The grant has been approved for 2 years, to start in July 2016.The CCM have requested that the key implementing partner - so called Principal recipient be UNDP Angola. UNDP will act both a direct implementer as well as oversight to other implementing partners main of which being the National AIDS Institute (INLS).The project will address the key current challenges in the fight against HIV both from the medical and human rights perspective.

Contributing Outcome (UNDAF/CPD, RPD or GPD): Indicative Output(s): By 2019, Angola has put into place and is implementing policies and strategies to promote inclusive and sustainable growth, leading to graduation from the least developed countries group. CPAP- Output 1.5: National institutions, systems, laws and policies strengthened for equitable delivery of HIV and related services.	**Total resources required:**	30,002,272
	Total resources allocated:	
	UNDP TRAC:	
	Donor:	30,002,272
	Donor:	
	Government:	
	In-Kind:	
	Unfunded:	

Agreed by (signatures)[1]:

Government	UNDP	Implementing Partner
Print Name: LUIS GOMES SAMBO	Print Name:	Print Name:
Date: 04.08.16	Date:	Date: 04/08/16

[1] Note: Adjust signatures as needed

I. DEVELOPMENT CHALLENGE

Angola has a population of 26 million people, with 50% under the age of 15. The prevalence of HIV among adults 15-49 years was estimated at 2% in 2013. Heterosexual contact is the principal mode of HIV transmission in Angola. The second most important mode of HIV transmission is peri-natal and occurs when the mother passes HIV to the child during pregnancy, at birth or during breastfeeding. Angola's burden for HIV in TB cases is about 11% (i.e.11% of TB patients are co-infected with HIV).

While general HIV prevalence in adults are currently lower than in other SADC countries (under 2,5%), the preoccupying factors are: the high estimated mother to child transmission (estimated at 25%), the low estimated adherence of patients on ARVs (estimated at 50%), the non-inclusion of key populations in the National Strategic Plan for HIV/AIDS and the lack of systemic handling of co-infection HIV/TB. The underlying causes are the lack of monitoring as well as gaps in human rights approaches and governance. The project will address the following development challenges:

HIV among key affected populations in Angola

Whereas Angola has a generalized HIV epidemic, there are pockets of concentrated epidemics especially among KPs. In Angola, KPs include sex workers and their clients, MSM and TGs. Other vulnerable groups that need special attention are miners, truck drivers, prisoners, young girls and young women, PLHIV, sero-discordant couples, fishing communities and migrant workers.

KPs are at higher risk of HIV infection or transmission, and likely to face societal barriers to accessing general HIV prevention and care interventions. KPs play a key role in the way HIV spreads, and their involvement is vital for an effective and sustainable response to HIV. KPs are also at a higher risk of other infections such as syphilis, Hepatitis B and Hepatitis C.

HIV prevalence among KPs is much higher than that of the general population. A 2011 behavioral & serological survey conducted among men who have sex with men in Luanda estimated the MSM population size for Luanda at 6,236 with an adjusted HIV prevalence at 3.8%. 50% of participants identified themselves as bisexual, 25% as MSM, and 18% homosexual/gay. Additionally 37% reported having participated in commercial sex with men, women, or transvestites (often concurrently). Another study conducted in Luanda in 2011, with a sample of 351 men, having sex with men, indicated that the HIV prevalence in this group is around 8.2%. Based on the information above, it is easy to see how HIV could be transmitted from MSMs to the general population. The study also reported that only 38 % of this high-risk group had ever tested for HIV. Nearly half the participants (46 %) reported experiencing homophobia (physically attacked, offended or discriminated against) and 25% reported being physically forced to have sex against their will.

Among sex workers, in 2006 a behavioral study has been conducted in two cities with a sample of 1,001 sex workers in Luanda and 327 sex workers in Cabinda. Results showed an HIV prevalence

of 23%. This study also highlighted that this population had very little knowledge and a low perception of infection risks (23.3%), 97% have heard at least once about HIV/AIDS and 67% used preservatives. A biological and behavioral surveillance survey (BBSS) conducted in 2009 examined transactional sex among 500 women (aged 15-25 years old) living in a town bordering Namibia in Angola. It found that 8.5 % of the participants were positive for HIV while 3.4 % tested positive for syphilis. Nearly half (46 %) reported never having an HIV test, half reported having at least one partner in the last year who was more than 10 years older, and 76.5 % reported having concurrent relationships in their last partnership. A third of the young women reported being forced to have sex against their will at some point in their lives, and 16 % reported being beaten by a sexual partner in the last year. Another study was conducted in Cunene Province (2011), with a sample of 500 Sex workers (SW), demonstrated that HIV prevalence was around 7.2% in this vulnerable group.

KPs, Human Rights Barriers and Gender Inequalities

The extent of human rights barriers in TB and HIV services provision is not well documented. Generally there is low understanding on the part of patients, health care providers and general public with regard to legal and patient rights in the provision of health services; the existing laws and regulations do not directly address specific needs of KPs with respect to health services provision and human rights. There is an AIDS law (Presidential Decree nº 08/04/2004) that aims to protect PLHIV from discriminatory practices. Although Angola passed the 2004 HIV and AIDS Prevention and Control Act that is intended to promote patients' rights and stigma free services, the act does not explicitly address the needs of KPs.

Stigma and discrimination against sexual minorities (LGBT/MSM), however subtle, contribute as a barrier to access health services. Articles 70 and 71 of the penal code, inherited from the colonial regime and as yet not revised, prohibit homosexual acts, considering them an offense to public moral. As a result, this high-risk population is largely hidden and has not been reached with any degree of success by HIV prevention services.

Moreover, a number of studies have shown that the perception of risk in relation to men's health is very low, leading to the adoption of risky behavior (such as not using condoms) and neglect of personal health. Together, these factors place MSM in the vulnerable population category and, as the data show, as a high incidence with need of strategic interventions. In addition to discrimination, sex work is not legalized in Angola. Thus, many sex workers who are victims of violence do not report these incidents to the authorities.

The Constitutional Law[2] adopted in 2010, Article 35, reaffirms gender equality in the family, in society and in the state. Men and women have equal rights and should have access to equal opportunities. However, there are customs and practices that discriminate against women in social, cultural, economic and political contexts, and that reinforce gender inequality. The choice whether or not to have children, agreeing on whether to use the condoms or not, or the decision to go to the health clinic is not left to the woman. It is the man who decides when the woman can seek health care, use condoms or any form of contraception within and outside marriage. Social practices reinforcing gender inequality include the acceptance that a man can have multiple

[2] *ANEXO Nº 20, Lei Constitucional de Angola*

partners in a stable relationship, and premature marriage. All this makes women more vulnerable and at greater risk to HIV infection.

Health Systems Analysis and Context

The National Health System in Angola includes three sectors: the Public, the Private and the Traditional sector. The National Health Service (NHS) is composed by all health facilities under the supervision of the Ministry of Health (MINSA), meaning under the coordination and methodological guidance of MINSA and under the management of Provincial Governments and Municipal Administrations, totalling to 2,366 health units in the three health care levels.[3] The for-profit private sector is comprised of private clinics that provide services to a large proportion of the population especially in large urban centres. The not for-profit health sector delivers services from health facilities managed by NGOs and Faith Based Organizations, assisting especially the poorest populations. The Traditional sector (traditional medicine) is mostly restricted to rural areas and provides services to a considerable portion of the population, especially where there is poor formal health service coverage. An important percentage of health expenditure is in the private for-profit sector.

Domestic funds financed 98% of public health care. The Government paid (67%) of total public health expenditure; The remainder was paid directly by households (24%) and by other funds (9%)(Source: WHO Health System Financing Country Profile, 2013). Total health expenditure, as a proportion of the state budget, has remained relatively stable in the same period, with an average of 4.58%. In 2012 the government produced the National Health Development Plan (PNDS), an ambitious plan for investment in health system and services through to 2025.

Community Systems Analysis and Context

The Angola health care has for decades been based on hospital care and therefore, there has never been a structured community-based health care system. The country never had a substantive policy regarding the organization of the community based services. However, there were several attempts from partners to establish a community health workforce, known as Community Health Agents (ACS) in different Provinces. Community activities have not been sustainable, lasting only until the end of their respective projects. With no guidance from the Ministry of Health, NGOs and partners had different approaches to CSS in general, as well as the scope of activities and processes for the management of ACS.

The existence of networks of NGO and CBO serve to protect the democratic process, respect of human rights, transparency and social accountability. Community activities and services have been proven to be essential for achieving improved health outcomes for the three diseases. Community peer members that are also people living with HIV (PLHIV) and key population are in a better position to understand and address the needs of affected populations bringing more

[3] The primary healthcare level includes the health posts and centres as well as the municipal hospitals; the secondary level is represented by the general or provincial hospitals and the specialized ones, where the primary level facilities refer patients to; the third level is made by nacional or central hospitals that are reference from the secundary facilities – National Health Policy, Presidencial Law n° 262/10 of the 24th November, DR I Série, nº 222.

credibility, trust in the service and relevance to the messages transmitted; encouraging communities to use health services delivered by the NHS.

MINSA and the Ministry of Territorial Administration (MAT) have worked to develop a policy for the deployment of Community and Health Development Agents (*Agentes de Desenvolvimento Communitario e de Sanitaria)* also called "ADECOs" at community level for several community based interventions including health prevention and promotion activities (Annex 32-RCN ADECOs Policy). MAT has declared an absolute commitment to pay ADECOS as a formal part of the health system from 2018. In 2014, the ADECOS national policy framework was approved and instituted to replace the several isolated community initiatives.

The role of ADECOS will be social mobilization, promotion of healthy behaviours, prevention of diseases, monitoring of treatment for some communicable diseases, referral from communities to health facilities and vice versa. However, there is recognition that the disease programmes have used ACS successfully for HIV counselling and testing, and TB DOTS. Angola has submitted an HSS concept note to support ADECOS and INLS/PNCT will leverage their roles during TB/HIV program implementation.

The above preoccupations are particularly impacting on lower socioeconomic strata of population. The new HIV grant of the Global Fund in Angola under the leadership of UNDP Angola will focus on tackling these issues, working together with MoH and civil society partners.

II. STRATEGY

The project is based on the following strategies:

Prioritization of high need - high impact interventions: The reduced financial resources required the country to go through a prioritization process on what modules to invest in. With reference to the results of an investment case scenario for Angola, the country chose the most cost effective interventions for scaled up (ART, PMTCT, KPs, TB/HIV).

Improving TB and HIV joint programming:. Specific joint programming activities have been identified for roll out and will include joint supervisory visits; joint planning and training activities, co-location of ART and TB services and a gradual expansion of the basic package of services for KPs to include both HIV and TB screening amongst other services on offer. Frequent coordination meetings are planned including joint program reviews. Efforts at leveraging TB and HIV resources at facility level will be initiated. Prioritization of regions with high burden of TB/HIV co-infection is also a key component of this strategy.

Ensuring commodity security to sustain gains in the ART/PMTCT and TB programs: Angola is committed to sustain the gains made in reducing morbidity and mortality related to the HIV ART program; the reduction of new HIV and TB infections from the prevention programs. The strategy is to include continuous dialogue with the MoH on the governmental organization of the purchasing function

Resource leveraging for efficiencies: Effective leveraging of resources from other donors and partners in the country is another key strategy in this application. Specific consideration has been given to the resources expected from the World Bank, USG-PEPFAR and other UN agencies.

Prioritization of KPs and other vulnerable groups: Addressing needs for KPs is critical to the national response as they drive the HIV epidemic. FSWs, MSM and Miners and Truck drivers are as population groups with elevated HIV prevalence rates and drivers of the epidemic. The intent is to leverage existing investments by other partners including PEPFAR to increase service coverage to these populations.. Gender considerations have also been made to improve service access to young women 15-24 years out of school who have been noted to be more vulnerable to HIV infection. The prevention for adolescents and youth module is specifically targeted at these groups, including adolescents and young people. There is a plan in this grant to train health workers and ACS to meet the specific needs of KPs.

Inclusion of Truck drivers: Long distance truck drivers have been known as major drivers of HIV transmission. Angola is part of two major African corridors. There are 51,429 Km of roads in Angola and most of freight in Angola is transported by trucks.
Transport sector workers are more likely to acquire the HIV infection. Transport workers could also serve as bridge populations linking with the general population.

Inclusion of Miners: As per beginning of 2016, the mining industry in Angola consisted of mining for diamonds. While there is ongoing investment in gold, copper, iron and phosphates mining, none of them has yet entered the production phase. About 7,000 miners work for the official diamond mining companies, but many estimative 50,000 in illegal mining. They will be in the focus of the HIV project

Prioritisation of girls out of school:
To increase safer behaviours among this most vulnerable group it is essential to engage with them and their culture in order to make HIV prevention relevant to them

Improving service access by children: reducing the current high transmission rate is heavily targeted. Viral load follow-up for at-risk infants will be improved

Project Components
More specifically the project will achieve this through the following Components:

I. Increase adoption of safer sexual behaviour among key populations (MSM, SW); *For the first time in Angola, key HIV risk populations will be reached with governmental interventions supported by UNDP Angola. These populations are under most risk of stigma, discrimination and transmission*

II. conduct seroprevalence studies for truck drivers and miners so that adequate approaches can be adopted based on the evidence gathered and analysed; Angola lacks reliable data and the studies will help to enlarge the data source

III. Reduce transmission of HIV from mother to child by providing comprehensive PMTCT services; the current estimated transmission rate of 25%, one of the highest in the world should be cut by 40%. This is also one of main targets of President's HIV Plan

IV. Expand provision and increase quality of comprehensive HIV and AIDS care and treatment including ART services in public and private sector facilities and increase adherence. While the coverage may not increase due to economic crisis, major advances should and can be undertaken in quality and stability of service

V. Girls out of school being one of most vulnerable groups, provide knowledge to girls out of school to improve self-empowerment and decisions on own life; up to now, young people at schools have been targeted.

VI. Strengthen national institutional capacity of the public and faith based sector to coordinate HIV interventions; This will allow for sustainability

VII. Significantly improve monitoring and quality of data; Currently data is missing, so that thorough analysis and decision making are impossible

VIII. Provide significant part of vital health products (ARVs and tests) in a current difficult economic environment. Work together with MoH to ensure supply chain sustainability.

III. RESULTS AND PARTNERSHIPS

Expected Results

The key results will include:

- Increased adherence of patients on ARV treatment from baseline of 50%.
- Lowered mother-to-child transmission rate from estimated baseline of 25%.
- Integration of TB prophylaxis into practical national care protocol.
- Implementation of case notification on national level.

Resources Required to Achieve the Expected Results

Two thirds of funding, 21 million USD, will be required to purchase, internationally, ARV treatments for est. 40,000 patients for 2 years and 1.5 million HIV tests. The rest of tests, drugs for TB prophylaxis in seropositive people, STI drugs etc. will be provided by outside sources - MoH and UNICEF.

The current PMU at UNDP will be slightly enlarged to 9 staff

Implementing partners INLS, UNFPA and to-be-selected non-governmental partners will provide own staff supported by national consultants to be paid by the grant. The resources are appropriately budgeted for in an approved detailed budget.

Partnerships and decentralization

A significant amount of activities will be implemented by partners. The main implementing partner will be INLS, a governmental stakeholder. Partnerships will be strengthened between INLS and DPS, RMS, public and faith based healthcare units providing ARV treatment, as well civil society organizations / individuals providing support to patients on HIV and HIV/TB treatment, MSM and SWs. Activists can be supervised directly by health units or at municipal level. Other contractual partnerships will be concluded with UNFPA and an NGO based on a bidding procedure

Risks and Assumptions

Risk	Rating	Assumptions -	Mitigation Strategy
Financial Sustainability	High	Financial and economic crisis having impact on government fiscal policies and on health financing	UNDP will advocating with Mistry of Health in order to establish financial sustainability mechanisms that will sustain the gains of GF investments in HIV and TB control.
Supply chain governmental contribution		There has to be a clear understanding of governmental contribution to the supply chain and clear controls	*Procurement and supply chain management:* Procurement of both HIV and TB medicines and commodities can be managed by single supply chain again, hence leveraging cost reduction through bulk procurement and shipping. This creates a room for further collaboration in HIV and TB services at the level of quantification and down the whole SCM cascade
Prevention programs for general population	Medium/High	Accessibility of free condoms is poor as they are available in health facilities only. Negative attitude on the use of condoms among sexually active populations.	The following intervention areas is a priority: *HIV Counselling and Testing*: Because of the economic crisis and the need to request ARV to sustain coverage, counselling and testing in the general population will be sustained at its current level Counselling and testing services will put more focus key populations (MSM and TG, FSW), and other vulnerable populations (prisoners, truck drivers, miners, young girls and women, clients of sex workers),

			Promotion of condoms: This intervention will extend the promotion, male condoms for HIV prevention, placing condoms in strategic locations. The development of the National Communication Strategy constituted a pillar of interconnection with various sectors of civil society, including PLWHIV and AIDS organizations and community health
Prevention programs for adolescents and youth	Medium	According to epidemiological data, adolescent girls and young women are among the most vulnerable populations with high infection rates, teenage pregnancies and abortions in Angola.	Investment in this module will target adolescent girls in schools and colleges and young women out-of-school through a number of interventions including: Community sensitization through community agents and other partners and radio and TV campaigns; training of formal and peer educators through CSOs , mobile units, promoting empowerment, sexual and reproductive rights to young women out of school in prioritised municipalities and linked to clinics providing youth friendly services and access to modern contraception and treatment of STI
Prevention programs for Key Populations (MSM and TG, FSW, Truck drivers and miners)	High	Stigma and discrimination against PLHIV as well as Key affected people (KPs). The law on HIV/AIDS and rights of PLHIV is not adequately disseminated and fully operational.	1000 MSM and 9500 will be reached, and a seroprevalence study for truck drivers and miners will be conducted. This is the first time that the KP will be addressed in Angola together with a national governmental partner
PMTCT	High	Angola has adopted Option B+ strategy to eliminate HIV transmission from mother to child. Challenges identified to achieve PMTCT include current baseline (25% transmission rate, one of world's highest) low institutional delivery coverage (40% MICS 2011), and ANC attendance rate of 70% at least once among pregnant women, HIV stigma and discrimination, and lack of male involvement in PMTCT strategy.	The strategy is to include continuous dialogue with the MoH on the governmental organization of the purchasing function. The baseline data was collected through routine reporting. A verification of data quality will be conducted during the length of the grant of GF

Treatment, Care and support	Medium	The National ART Guidelines have been revised in line with the WHO 2013 ART guidelines.	The focus of the above allocation interventions is to improve the quality of treatment and care among adults and children receiving ART and adherence.
HMIS and Monitoring & Evaluation	High	INLS has procured an HIS system in 2013 and finds that it does not provide the data required for its purposes Whereas both HIV and TB programmes have an urgent need to develop functional systems, they recognise the need to engage with the broader long term development of national systems, and will work alongside the development of the national HIS to develop modules that can be incorporated in the national system when appropriate.	In order to overcome this INLS is introducing key instruments for data collection for loading into the system to provide the first level of strategic information. INLS and PNCT have gained valuable experience through their data collection and recognition of the shortcomings of their systems. The Ministry of Health, financed through the approved HSS concept note, is planning to strengthen an integrated and robust HIS system at national and sub-national levels, and INLS will participate in this process in line with the principle of the "Three Ones".
Programme Management	Medium	Delay in recruitment could affect the implementation of the project.	This intervention plans to continue supporting the PR in grant implementation to monitor the SR activities, and the INLS in its coordination role of the HIV/AIDS multi-sectoral response in Angola. INLS functions as a decentralized body to undertake its coordination role at provincial and municipal levels. The application will support the training of key program staff for the programme, particularly in financial management and monitoring and evaluation.

Stakeholder Engagement

The target groups are in first order the vulnerable populations to HIV: sex workers, MSM, truck drivers, miners, TB patients, pregnant women and girls out of school. Drafting and validation of a Key Populations National Plan is part of the project. The engagement of stakeholders will take place through the Country Coordinating Mechanism, the national civil society and informal knowledge sharing.

South-South and Triangular Cooperation (SSC/TrC)

The project will source consultants and lecturers from SADC countries. The project will draw on good practices in other SADC countries.

Knowledge

Various knowledge products have been planned and budgeted for, together with the support of 25% of UNDP Angola national communications officer. Among communication/knowledge products are: A telephone hotline for health staff, Facebook and other social media platform for MSM, teaching videos or staff and activists, leaflets on various themes, cinema in the village, radio shows and interviews in the media. They are described in the detailed budget.

In order to give proper recognition to the Global Fund for funding, a logo of the Global Fund should appear on all relevant publications of the project, including among others, the equipment of the project purchased with funds. Any citation on publications regarding activities financed by the Global Fund should also provide adequate recognition to the donor. The logo UNDP should be separated from the logo of the Global Fund, if possible, as UN visibility is important for security purposes.

Sustainability and Scaling Up

The project is not creating any parallel systems, but reinforcing the existing ones. Main (implementing) partners is the INLS and MoH, so that national ownership is guaranteed. Main approach to enhance capacity is to: a. strengthen communication between all partners and levels b. enhance supervision, monitoring effort and on-the job training. The sustainability relies on:

1. Creating and enforcing robust and transparent procedures.
2. Best use of economic resources.
3. Being able to hire and keep qualified staff long term

IV. PROJECT MANAGEMENT

Cost Efficiency and Effectiveness

For purchasing, representing 68% of the funding to be used, UNDP has streamlined international procedures and prices which are one of the lowest in the world for these commodities (ARVs, HIV tests).

The PMU at UNDP Angola will be only slightly enlarged by est. 3 more posts. For large part of the grant, existing national resources of the public health sector will be used (i.e. existing cars, existing national staff). A detailed budget has been negotiated with the funding partner based on cost efficiency and effectiveness factors.

Project Management

A project management unit of 8 dedicated staff at UNDP will manage the project:

- International Project Coordinator
- Senior Procurement officer

- Technical Advisor
- Financial Officer and Financial Assistant
- M&E Officer
- Operations Assistant
- 2 drivers

Supported by UNDP senior management, operations and communications. Further support will be received from the UNDP - GFATM team partnership in Geneva.

V. RESULTS FRAMEWORK[4]

This project will contribute to achieving the following Country Programme Outcome as defined in CPAP or CPD: Outcome 1: Inclusive and sustainable growth, leading to 'graduation' from the least developed countries; output 1.5: National institutions, systems, laws and policies strengthened for equitable delivery of HIV and related services.

Intended Outcome as stated in the UNDAF/Country [or Global/Regional] Programme Results and Resource Framework: Strengthening the national response for the control of STI/HIV and viral Hepatitis to ensure an HIV prevalence rate of less than 3%										
Outcome indicators as stated in the Country Programme [or Global/Regional] Results and Resources Framework, including baseline and targets: Maintain the prevalence of HIV positive pregnant women under 3% until 2018. Reduce the rate of vertical transmission below 5% by 2018. Increase PMTCT coverage from 39% to 90% of HIV positive pregnant women by 2018 Increase from 52% to 90% the follow-up of positive pregnant women on antiretroviral treatment (ART) by 2018 Increase from 74% to 90% the percentage of male and female sex workers who report condom use with their last client 2018										
Applicable Output(s) from the UNDP Strategic Plan:										
Project title and Atlas Project Number:										
EXPECTED OUTPUTS	**OUTPUT INDICATORS[5]**	**DATA SOURCE**	**BASELINE**		**TARGETS (by frequency of data collection)**					**DATA COLLECTION METHODS & RISKS**
			Value	**Year**	**Year (2016)**	**Year (2017)**	**Year (2018)**			
	HIV O-1: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	CDC survey	46%	2015	51%	56%	59%			Specific surveys and research studies

[4] UNDP publishes its project information (indicators, baselines, targets and results) to meet the International Aid Transparency Initiative (IATI) standards. Make sure that indicators are S.M.A.R.T. (Specific, Measurable, Attainable, Relevant and Time-bound), provide accurate baselines and targets underpinned by reliable evidence and data, and avoid acronyms so that external audience clearly understand the results of the project.

[5] It is recommended that projects use output indicators from the Strategic Plan IRRF, as relevant, in addition to project-specific results indicators. Indicators should be disaggregated by sex or for other targeted groups where relevant.

	HIV O-5: Percentage of sex workers reporting the use of a condom with their most recent client	Specific surveys and research (SADC survey)	82.7%	*2015*	84%	85%	90%				Specific surveys and research studies
Prevention programs for general population	***2.1 GP-1: Number of women and men aged 15+ who received an HIV test and know their results***	*Patient records*	1.191.972	2014	*900.000*	1.200.000	1.300.000				Specific surveys and research studies
	2.2										
Prevention programs for adolescents and youth, in and out of school	***YP-1: Percentage of young people aged 10–24 years reached by life skills–based HIV education out of school***	*Survey*	*N/A*		*3%*	*5%*	*6%*				Specific surveys and research studies
											Specific surveys and research studies
Prevention programs for MSM, sex workers and TGs	***KP-2a: Percentage of MSM reached with HIV prevention programs - individual and/or smaller group level interventions***	*Operational Research*	*5%*	*2015*	*N/A*	*5.6%*	*5.6%*				Specific surveys and research studies
	KP-1c: Percentage of sex workers reached with HIV prevention programs - defined package of services	*Specific surveys and research (SADC survey 2015)*	*5,2%*	*2015*	*4%*	*10%*	*12%*				Specific surveys and research studies
PMTCT	PMTCT-2: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	*Reports from PTV-providing units*	*40,2%*	*2014*	*46%*	*55%*	*58%*				The baseline data was collected through routine reporting. A verification of data

	PMTCT-3: Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	*Reports from involved units*	*2%*	*2015*	*4%*	*5%*	*6,3%*				quality will be conducted during the length of the grant of GF
Treatment, care and support	*TCS-1: Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV*	*Reports (health facilities to INLS)*	*22,5%*	*2014*	*27%*	*29%*	*31%*				Specific surveys and research studies
	TCS-1: Percentage of children currently receiving antiretroviral therapy among all adults and children living with HIV	*Reports of health facilities to INLS*	*15,3%*	*2014*	*9,7%*	*20,3%*	*20,3%*				Specific surveys and research studies
	(IRRF- 3.3.1.B.1.1): Number of males receiving antiretroviral treatment	*Reports of health facilities to INLS*	*27.792 8,2%*	*2015*	*20000 5.7%*	22.500 *6.3%*	24.000 6.7%				Specific surveys and research studies
	(IRRF- 3.3.1.B.2.1): Number of females receiving antiretroviral treatment	*Reports of health facilities to INLS*	*47.982 14,1%*	*2015*	*75000 21.%*	*82500 23%*	87.874 24.5%				Specific surveys and research studies
	(IRRF- 3.3.1.B.3.1): Total number of people receiving antiretroviral treatment	*Reports of health facilities to INLS*	*75.774 22,2%*	*2015*	*95000 27%*	105.000 *29%*	111.874 *31%*				Specific surveys and research studies
TB/HIV	*TB/HIV-4: Percentage of new HIV-positive patients starting IPT during the reporting period*		*N/A*		*3%*	*5%*	*7%*				Specific surveys and research studies
	TB/HIV-1: Percentage of TB patients who had an HIV test result recorded in the TB register	*Reports PNCT*	*48,8%*	*2014*	*26,4%*	*29,4%*	*31,6%*				Specific surveys and research studies
	TB/HIV-3: Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings		*N/A*		*1,7%*	*2,1%*	*3,5%*				Specific surveys and research studies

	TB/HIV-2: Percentage of HIV-positive registered TB patients given anti-retroviral therapy during TB treatment	*Report 2014 PNCT*	*N/A*		*66,9%*	*80,4%*	*85%*				Specific surveys and research studies Specific surveys and research studies

VI. MONITORING AND EVALUATION

In accordance with UNDP's programming policies and procedures, the project will be monitored through the following monitoring and evaluation plans: *[Note: monitoring and evaluation plans should be adapted to project context, as needed]*

CLÁUDIA INPUTS

Monitoring Plan

Monitoring Activity	Purpose	Frequency	Expected Action	Roles	Partners (if joint)	Cost (if any)
Development of the AWP	Annual Work Plans (AWPs) are prepared every year, on the basis of intended results, strategies, budgets and implementing partners identified in the agency's CPAP, reflecting achievements and lessons learned of the preceding year. They set out interventions organized around outcomes, outputs and/or implementing partners (for example, in the form of projects).	Annual : January 15th	The Annual Work Plan (AWP) provides detailed activity planning and sets out what will be accomplished during the. The AWP contains: i) the expected outputs; ii) the activities to be carried out towards achievement of the expected outputs; iii) the time frame for undertaking the planned activities; iv) those responsible for carrying out the activities, and v) the inputs to be provided for each activity.	Programme Manager Project Manager M&E Office		
Quarterly update of the AWP/QWP	Reporting on performance and lessons to facilitate learning and support accountability.	Quarterly revision : March 30, June 30, September 30	Report performance based on evidence of progress made and decisions taken in project; Collected progress data against annual priorities and operational performance data against financial and efficiency targets, in the frequency stated.	Programme Manager Project Manager M&E Office		
Annual Project Target setting in ATLAS per Project ID (output ID), based on AWP	Compare and analyze evidence against defined programming and operational baselines, milestones, and targets	Annual : January 20th	An analysis of collected evidence against targets and progress data, including an assessment of why progress against results is above, at, or below targets	Programme Manager Project Manager M&E Office		

Track results progress	Progress data against the results indicators in the RRF will be collected and analysed to assess the progress of the project in achieving the agreed outputs.	Quarterly, or in the frequency required for each indicator.	Slower than expected progress will be addressed by project management.	Programme Manager Project Manager M&E Office		
Monitor and Manage Risk (in Atlas)	Identify specific risks that may threaten achievement of intended results. Identify and monitor risk management actions using a risk log. This includes monitoring measures and plans that may have been required as per UNDP's Social and Environmental Standards. Audits will be conducted in accordance with UNDP's audit policy to manage financial risk.	Quarterly revision: March 30, June 30, September 30	Risks are identified by project management and actions are taken to manage risk. The risk log is actively maintained to keep track of identified risks and actions taken.	Programme Manager Project Manager M&E Office		
Monitoring of the project indicators - including the SP indicators (in preparation of quarterly project reporting)	Verify output progress and/or completion at least twice per year per project, and compare progress data with baseline and targets for all indicators in the results framework	Quarterly monitoring : April 30, June 30, October 30 Annual report : January 15	Environmental/social impacts of the projects; access to equipment installed through site visits; verify delivery of products and services to target beneficiaries and the location, proper upkeep, safety and security of equipment.	Programme Manager Project Manager M&E Office		
Quarterly field monitoring by programme staff, project staff Joint field monitoring with stakeholders : quality assurance	Verify output progress and/or completion at least twice per year per project, and compare progress data with baseline and targets for all indicators in the results framework	Quarterly/ least twice per year	Monitoring is a continuous management function that provides decision-makers with regular feedback on the consistency or discrepancy between planned and actual results and implementation performance	Programme Manager Project Manager M&E Office		
Learn	Knowledge, good practices and lessons will be captured regularly, as well as actively sourced from other projects and partners and integrated back into the project.	At least annually	Relevant lessons are captured by the project team and used to inform management decisions.	Programme Manager Project Manager M&E Office		
Project Quality assurance system	Conduct Design stage Project QA Assessment, including identifying management actions to address any areas that need improvement; Conduct Implementation stage Project QA Assessment annually, including identifying management actions to address any areas that need improvement;	July to December	An analysis of programming quality is conducted against quality standards	Programme Manager Project Manager M&E Office		

	Conduct Closure stage Project QA Assessment and add summary comments and lessons learned as needed.					
Social and Environmental Standards	Design and Appraisal: Identify and plan management actions to address significant risks, including dispute risks, and to build or support national risk management capacities, and integrate into Project Document; Implementation: Assess ongoing compliance with the Social and Environmental Standards as part of annual quality assurance; Closure/ Evaluation: Review social and environmental and risk prevention and management experience; note lessons learned and opportunities for improvement in project closure/evaluation.	Annually	(i) strengthen the social and environmental outcomes of Programmes and Projects; (ii) avoid adverse impacts to people and the environment; (iii) minimize, mitigate, and manage adverse impacts where avoidance is not possible; (iv) strengthen UNDP and partner capacities for managing social and environmental risks; and (v) ensure full and effective stakeholder engagement, including through a mechanism to respond to complaints from project-affected people.	Programme Manager Project Manager M&E Office		
Annual Project Quality Assurance	The quality of the project will be assessed against UNDP's quality standards to identify project strengths and weaknesses and to inform management decision making to improve the project.	Annually	Areas of strength and weakness will be reviewed by project management and used to inform decisions to improve project performance.	Programme Manager Project Manager M&E Office		
Review and Make Course Corrections	Internal review of data and evidence from all monitoring actions to inform decision making.	At least annually	Performance data, risks, lessons and quality will be discussed by the project board and used to make course corrections.	Programme Manager Project Manager M&E Office		
Quarterly Progress Report	Report performance based on evidence of progress made and decisions taken in project, to support accountability and communication of results and lessons learned	Quarterly Project Report (April 30, June 30, October 30);	Quarterly accomplishments, lessons learned/problems faced during the execution of the activities and the planned activities for the next quarter. Quarterly report to be prepared for 1, 2 and 3 quarters. Report for 4 quarter to be combined with annual progress report.	Programme Manager Project Manager M&E Office		

Annual Progress Report	A progress report will be presented to the Project Board and key stakeholders, consisting of progress data showing the results achieved against pre-defined annual targets at the output level, the annual project quality rating summary, an updated risk long with mitigation measures, and any evaluation or review reports prepared over the period.	Annually, and at the end of the project	Annual accomplishments and outputs, indicators and targets and the efficiency and effectiveness with which they are produced; budget and final report for the year completed; update of Project workplan; lessons learned, recommendations and suggestions for re-orientation of activities (if necessary)	Programme Manager Project Manager M&E Office		
Financial recording & reporting	Monitoring and control of project expenditures; financial management & reporting; Project resource data tracking inputted in and regularly accessed from, the Atlas system	Quarterly Project Report (April 30, June 30, October 30);	Detailed activities, budget, financial management & reporting			
Project Review (Project Board)	The project's governance mechanism (i.e., project board) will hold regular project reviews to assess the performance of the project and review the Multi-Year Work Plan to ensure realistic budgeting over the life of the project. In the project's final year, the Project Board shall hold an end-of project review to capture lessons learned and discuss opportunities for scaling up and to socialize project results and lessons learned with relevant audiences.	Specify frequency (i.e., at least annually)	Any quality concerns or slower than expected progress should be discussed by the project board and management actions agreed to address the issues identified. Minutes of meetings which reflect the discussions and decisions according to the functions of the PB outlined in document.	Programme Manager Project Manager M&E Office		
Terminal Report	Project accomplishments against outputs, targets and indicators; Project expenses and financial report; Records and evidences of all outputs; Lessons learned and recommendations for future actions.	The end of the project	Draws on evaluation findings to improve the quality of programmes, guide strategic decision-making on future programming and positioning, and share knowledge on development experience.	Programme Manager Project Manager M&E Office		

Evaluation Plan[6]

Evaluation Title	Partners (if joint)	Related Strategic Plan Output	UNDAF/CPD Outcome	Planned Completion Date	Key Evaluation Stakeholders	Cost and Source of Funding
e.g., Mid-Term Evaluation						

[6] Optional, if needed

VII. MULTI-YEAR WORK PLAN [7][8]

EXPECTED OUTPUTS	PLANNED ACTIVITIES	Planned Budget by Year				RESPONSIBLE PARTY	PLANNED BUDGET		
		Y1	Y2	Y3	Y4		Funding Source	Budget Description	Amount
Output 1 Prevention programs for general population	1.1Prevention programs for general population	598,904	1,480,786				GF		2,079,690
	Sub-Total for Output 1								2,079,690
Output 2 Prevention programs for adolescents and youth	2.1 Prevention programs for adolescents and youth	430,515	467,430						897,944
	Sub-Total for Output 2								897,944
Output 3 Prevention programs for Key Populations (MSM and TG, FSW, Truck drivers and miners)	Activity 3.1 Prevention programs for MSM and TGs	358,040	182,460				GF		540,500
	Activity 3.2 Prevention programs for sex workers and their clients	228,135	327,450				GF		555,585
	Activity 3.3 Prevention programs for other vulnerable populations (please specify)	176,138	763,259				GF		939,397

[7] Cost definitions and classifications for programme and development effectiveness costs to be charged to the project are defined in the Executive Board decision DP/2010/32

[8] Changes to a project budget affecting the scope (outputs), completion date, or total estimated project costs require a formal budget revision that must be signed by the project board. In other cases, the UNDP programme manager alone may sign the revision provided the other signatories have no objection. This procedure may be applied for example when the purpose of the revision is only to re-phase activities among years.

	Sub-Total for Output 3								2,035,482
Output 4 PMTCT	4.1PMTCT	289,700	272,920				GF		562,621
	Sub-Total for Output 4								562,621
Output 5 Treatment, Care and support	5.1Treatment, Care and support	13,302,256	5,764,247				GF		19,066,503
	Sub-Total for Output 5								6,362,360
Output 6 HMIS and Monitoring & Evaluation	6.1HMIS and Monitoring & Evaluation	459,085	416,085				GF		875,169
	Sub-Total for Output 6								875,169
General Management Support		459,085	416,085				GF		875,169
TOTAL									30,002,272

VIII. GOVERNANCE AND MANAGEMENT ARRANGEMENTS

Implementation, execution and coordination of the Project will be carried out as described below. In brief, main control mechanism of Global Fund being a CCM, chaired by the Minister of Health. This is to be supplemented through the appointment of a National Project Director supported by the Project Management Unit (existing unit and additional recruitment and selection of an international Project Manager, a Finance Assistant and a Technical Advisor).

The project will be implemented over a period of 2 years. The project will be nationally implemented DIM together INLS, UNFPA and national non-governmental organizations, in line with the Standard Basic Assistance Agreement (SBAA of 18 February, 1977)9 and the UNDP Country Programme Action Plan (CPAP 2015-2019 of 14 November, 2015) signed between the UNDP and the Government of Angola.
UNDP will elaborate and submit to the Global Fund the PUDR – Project Update/Disbursement Request – according to the schedule and requirements defined together with the Global Fund.

The UNDP will establish a financial reporting schedule with INLS according to the Global Fund requirements and will build the capacity to provide high quality and timely programmatic and financial reports. Recruitment of program staff will be conducted with involvement of parties.

Parties will meet regularly to: discuss procurement needs; forecast requirements; work out logistical arrangements; share lists of potential SR recipients to ensure no double funding occurs; share reporting formats; align processes and procedures; and, discuss programmatic challenges.

The PRs will be encouraged by CCM Secretariat to routinely communicate with each other to ensure they are able to respond effectively to any challenges that arise. Where issues and gaps arise, the PRs will be encouraged to work together to ensure the needs of the national response are met.

The lead SRs designated for this concept note are INLS for UNDP and PCNT for MoH. The lead SR have been selected as the main implementers since previous grants and have been assessed routinely to ensure that they still possess the capacity in managing and implementing GF grants among others.

The PR and SR will sign an agreement stipulating the roles and responsibilities of each party disbursements will be a performance based to ensure that the set targets in the PF are been met.

The CCM provides stakeholder oversight to the portfolio of Global Fund grants in the country. It is tasked with the responsibility of ensuring coordination of the PRs; and measuring and monitoring performance of the grants. The CCM provides a high-level formal and representative forum for all the partners from government, private sector, development partners, civil society, including

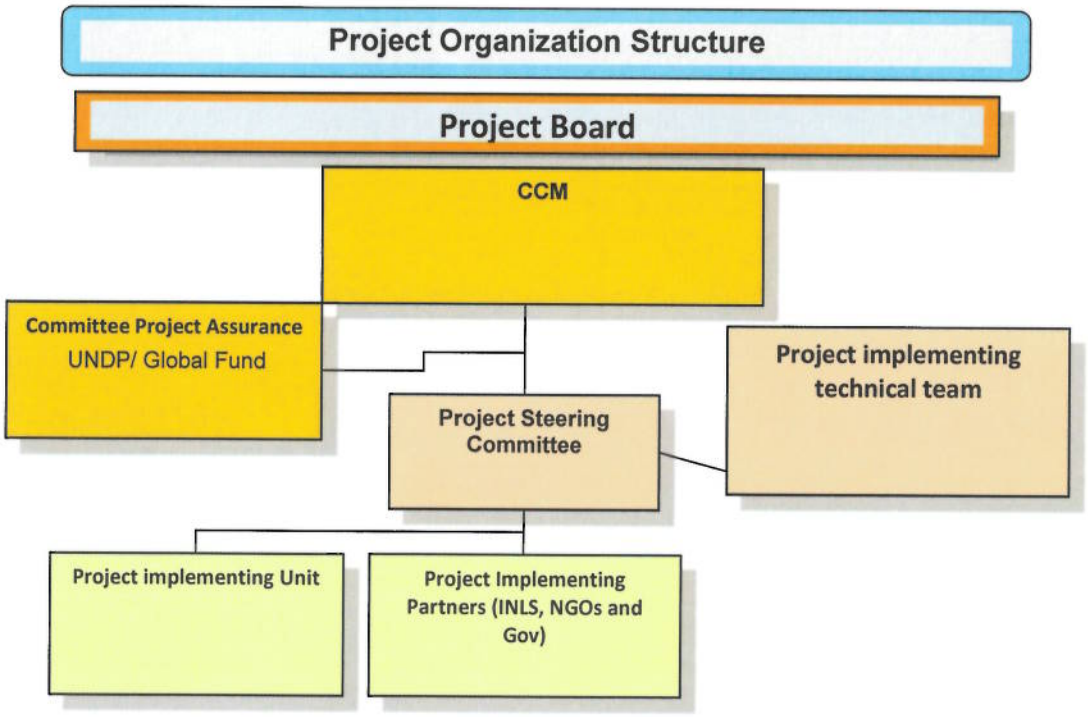
[9] In particular, Decision 2005/1 of 28 January, 2005 of UNDPs Executive Board approved the new *Financial Regulations and Rules* and along with them the new definitions of 'execution' and 'implementation'.

international NGOs, People leaving with diseases (PLWD) and Key population. The CCM provides a platform for information sharing, technical leadership and direction.

These reports are presented to the CCM members in their scheduled quarterly meetings to provide feedback and strategic direction on how the grants are performing and if there are any bottlenecks necessary steps and remedies are suggested to the PRs by the CCM.

How representatives of women's organizations, people living with the two diseases and other key populations will actively participate in the implementation of this funding request.

There has been involvement of different key stakeholders throughout the concept note writing process. They are represented in the CCM.



IX. Legal Context and Risk Management

Select the relevant one from each drop down below for the relevant standard legal text:

1. Legal Context:
   - ☐ Country has signed the Standard Basic Assistance Agreement (SBAA)
   - ☐ Country has not signed the Standard Basic Assistance Agreement (SBAA)
   - ☐ Regional or Global project

2. Implementing Partner:
   - ☐ Government Entity NIM)

- ☐ UNDP (DIM)
- ☐ CSO/NGO/IGO
- ☐ UN Agency (other than UNDP)
- ☐ Global and regional projects

Or click here for the MS Word version of the standard legal and risk management clauses.

X. ANNEXES

1. **Project Quality Assurance Report**

2. **Social and Environmental Screening Template** [English][French][Spanish], including additional Social and Environmental Assessments or Management Plans as relevant. *(NOTE: The SES Screening is not required for projects in which UNDP is Administrative Agent only and/or projects comprised solely of reports, coordination of events, trainings, workshops, meetings, conferences, preparation of communication materials, strengthening capacities of partners to participate in international negotiations and conferences, partnership coordination and management of networks, or global/regional projects with no country level activities).*

3. **Risk Analysis**. Use the standard Risk Log template. Please refer to the Deliverable Description of the Risk Log for instructions

4. **Project Board Terms of Reference and TORs of key management positions**