

# UNAIDS

## **An Evaluation of the contribution of the UNAIDS Joint Programme to strengthening HIV and Primary Health Care outcomes**

*Country case studies*

Angola



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## Abbreviations and acronyms

ADECOS	community development and health agent
AIA	Arquivo de Identidade Angolano—is a key population organization targeting LGBTQI+ focusing on activism and justice for women
AIDS	acquired Immuno-deficiency syndrome
ANC	ante natal care
ART	antiretroviral therapy
CSE	comprehensive sexuality education
CSO	civil society organization
DHIS	district health information system
DNSP	Direção Nacional da Saúde Publica—National Directorate of Public Health
DTG	Dolutegravir
EHG	Euro Health Group
EID	early infant diagnosis
HIV	human immuno-deficiency virus
ILO	International Labour Organization
INLS	National Institute for the Fight Against AIDS
IRIS	key population organization targeting SRHR services, HIV prevention messaging and testing along with referral for treatment and support of retention in care for MSM, gay men and transgender people, with a focus on young MSM and trans-gender.
JICA	Japan International Cooperation Agency
KP	key population
LGBTQI+	lesbian, gay, bisexual, transgender, queer or questioning, intersex
MMD	multi month dispensing
MoH	ministry of health
MSM	men who have sex with men
NCD	non-communicable diseases
NSP	national strategic plan
PEPFAR	(US) President’s Emergency Plan for AIDS Relief
PHC	primary health care
PLHIV	people living with HIV/AIDS
PMTCT	prevention of mother to child transmission
RSSH	Resilient and Sustainable. Systems for Health
S&D	stigma and discrimination
SCI	service coverage index
SDG	sustainable development goals
SIDA	Swedish International Development Cooperation Agency
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infections
TB	tuberculosis
UBRAF	unified budget results and accountability framework
UHC	universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children’s Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
WHO	World Health Organization

## Glossary of key terms

Term	Definition
<b>Communities</b>	Groups of people that may or may not be spatially connected, but who share common interests, concerns or identities. These communities could be local, national or international, with specific or broad interest <sup>a</sup>
<b>Community-led (AIDS) responses</b>	Actions and strategies that seek to improve the health and human rights of their constituencies, specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them <sup>b</sup>
<b>Community engagement</b>	A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes <sup>c</sup>
<b>Comprehensive HIV services</b>	Services provided across a continuum that addresses the prevention, testing, treatment, and care needs for people living with and affected by HIV. This may include combination HIV prevention, HIV testing, antiretroviral therapy (ART), management of co-morbidities and coinfections (e.g., tuberculosis (TB), sexually transmitted infections (STIs), viral hepatitis, cervical cancer, non-communicable diseases (NCDs), mental health conditions, etc.), and specific services and interventions for key and other populations (e.g., pre-exposure prophylaxis, harm reduction, condoms, lubricant).
<b>Comprehensiveness of care</b>	The extent to which the spectrum of care and range of available resources responds to the full range of health needs of a given community. Comprehensive care encompasses health promotion and prevention interventions, as well as diagnosis and treatment or referral and palliation. It includes chronic or long-term home care and, in some models, social services <sup>d</sup>
<b>Differentiated service delivery</b>	An approach that simplifies and adapts HIV services to better serve the needs of people living with HIV/AIDS (PLHIV) and to optimize the available resources in health systems <sup>e</sup>
<b>Empowerment</b>	The process of supporting people and communities to take control of their own health needs resulting, for example, in the uptake of healthier behaviours or an increase in the ability to self-manage illnesses. <sup>d</sup>
<b>Essential public health functions</b>	The spectrum of competences and actions that are required to reach the central objective of public health—improving the health of populations. This document focuses on the core or vertical functions: health protection, health promotion, disease prevention, surveillance and response, and emergency preparedness. <sup>d</sup>
<b>Health system</b>	All organizations, people, and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, family caregivers; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; and occupational health and safety legislation. The WHO health system framework identifies six health system "building blocks": leadership and governance, health financing, health workforce, health services, health information systems, and medical products, vaccines, and technologies <sup>f</sup>
<b>Health benefits packages</b>	The type and scope of health services that a purchaser buys from providers on behalf of its beneficiaries. <sup>d</sup>
<b>Integrated health services</b>	The management and delivery of health services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease



Term	Definition
	management, rehabilitation and palliative care services through the different functions, activities, and sites of care within the health system. <sup>d</sup>
<b>Interlinkages</b>	Joined or connected, with the parts that are joined often having an effect on each other
<b>Key populations/ vulnerability</b>	<p>Key populations are groups that have a high risk and disproportionate burden of HIV in all epidemic settings. They frequently face legal and social challenges that increase their vulnerability to HIV, including barriers to accessing HIV prevention, treatment and other health and social services. Key populations include gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs.</p> <p>Vulnerability refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk, and they may be outside of their control. These factors may include lack of the knowledge and skills required to protect oneself and others; limited accessibility, quality and coverage of services; and restrictive societal factors, such as human rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatize and disempower certain populations). These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.<sup>e</sup></p>
<b>Multisectoral action on health</b>	Policy design, policy implementation and other actions related to health and other sectors (for example, social protection, housing, education, agriculture, finance and industry) carried out collaboratively or alone, which address social, economic and environmental determinants of health and associated commercial factors or improve health and well-being. <sup>d</sup>
<b>People-centred care</b>	An approach to care that consciously adopts the perspectives of individuals, carers, families and communities as participants in and beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care. <sup>d</sup>
<b>Person-centred care</b>	Care approaches and practices in which the person is seen as a whole, with many levels of needs and goals, the needs being derived from their personal social determinants of health. <sup>d</sup>
<b>Primary care</b>	A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care. <sup>d</sup>
<b>Primary health care</b>	A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities. <sup>d</sup>
<b>Primary health care-oriented systems</b>	Health system organized and operated to guarantee the right to the highest attainable level of health as the main goal, while maximizing equity and solidarity. A primary health care-oriented health system is composed of a core set of structural and functional elements that support achieving universal coverage and access to services that are acceptable to the population and equity enhancing. <sup>d</sup>
<b>Service package</b>	A list of prioritized interventions and services across the continuum of care that should be made available to all individuals in a defined population. It may be endorsed by the government at national or subnational levels or agreed by actors where care is by a non-State actor <sup>d</sup>

Term	Definition
<b>Synergy</b>	The interaction of elements that when combined produce a total effect that is greater than the sum of the individual elements
<b>Universal Health Coverage</b>	Ensured access for all people to needed promotive, preventive, resuscitative, curative, rehabilitative, and palliative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose any users to financial hardship. <sup>d</sup>
<b>Vertical programmes</b>	Health programmes focused on people and populations with specific (single) health conditions. <sup>d</sup>

Sources for glossary:

- a) Community engagement: a health promotion guide for universal health coverage in the hands of the people. Geneva: World Health Organization; 2020
- b) Community-led AIDS responses: final report based on the recommendations of the multistakeholder task team [Internet]. UNAIDS; 2022 [cited 2023 Apr 29]. Available from: <https://www.unaids.org/en/resources/documents/2022/MTT-community-led-responses>
- c) WHO community engagement framework for quality, people-centred and resilient health services. Geneva: World Health Organization; 2017
- d) Operational Framework for Primary Health Care. Geneva: World Health Organization and UNICEF; 2020
- e) Updated recommendations on service delivery for the treatment and care of people living with HIV. Geneva: World Health Organization; 2019
- f) Everybody’s business: strengthening health systems to improve health outcomes: WHO’s framework for action. [Internet]. World Health Organization; 2007 [cited 2023 Apr 7]. Available from: <https://www.who.int/publications/i/item/everybody-s-business---strengthening-health-systems-to-improve-health-outcomes>
- g) UNAIDS terminology guidelines, 2015. [https://www.unaids.org/sites/default/files/media\\_asset/2015\\_terminology\\_guidelines\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf)

# Executive summary

## Introduction

The purpose of this case study was to generate evidence and learnings from the different ways in which the UNAIDS Joint Programme has supported countries to leverage PHC and HIV linkages across various contexts. The case study used a mixed methods approach combining qualitative and quantitative methods for data collection and analysis. An initial document and data review was supplemented by primary data collection through key informant interviews and focus group discussions with key stakeholders from the national and provincial levels (Benguela). Altogether, 20 key informant one-on-one interviews and seven focus group discussions were conducted through which a total of 88 key stakeholders shared their experiences.

National Health System in Angola is divided between the public, for-profit and non-profit and the traditional sector and guided by government health programs, which aim to achieve Universal Health Coverage (UHC) by 2025. The national government commitment to PHC has recently gained momentum with the signing of the Luanda Declaration on PHC and immunization and even more recent development of a PHC draft financing action plan. Angola has an estimated HIV prevalence of 1.5% and in 2022, there were 310 000 adults and children living with HIV in Angola with the number of new cases of HIV estimated at 15 000, compared to 20 000 in 2019.

## Key findings

Although the merit of integration, alignment and interlinkages between HIV and PHC is recognized by the individual Joint UN Team on AIDS agencies (Joint Team), conceptual clarity on what the Joint Team aims to achieve is less clear. There is a lack of clarity (by all stakeholders) and emphasis concerning HIV integration efforts within the PHC agenda including critical functions that focus on the continuum of care from comprehensive prevention of HIV to adherence and care, and importantly the health workforce and the community response.

However, individual agencies are designing and engaging in HIV activities that intersect with the PHC approach. The Joint Team has served a critical role in assisting with conceptualisation of the most recent, as well as the past three, national strategic plans (PEN VII) which reflect integrated service provision for three diseases in line with the tenants of PHC yet lacks a clear focus on PHC. Specific achievements related to applying the PHC approach to HIV responses were also noted, mainly implemented by individual Joint Team agencies as per their respective mandates. In addition to addressing HIV, the UN agencies design and implement programmes that address the broader social determinants of health including social, economic, and environmental factors in different sectors which could be further leveraged for improved HIV and broader health outcomes.

The evaluation identified a range of barriers to leveraging integration and interlinkages of HIV and PHC in Angola which included: the lack of a clear actionable PHC strategy and business plan; human resources capacity gaps; inadequate investment toward a coordinated and strong community response; data quality; stigma and discrimination and the lack of an enabling environment to mitigate its impact; insufficient coordination and siloed working style of the Joint Team; and weak coordination capacity of the MoH. Enablers or potential enablers to integrating HIV into PHC were also identified and included: The First Lady's initiative as an example of cultivating a champion for the convergent PHC/HIV agenda (with respect to PMTCT); private sector involvement, and the new UN Sustainable Development Cooperation Framework (UNSDCF 2024-2028) which includes a more prominent focus on PHC.

The evaluation found evidence of the Joint Team using HIV investments, assets, infrastructure and innovation to strengthen the wider PHC agenda, a notable example was the response to the COVID-19 pandemic tapping into HIV resources and programming. Engaging civil society in the HIV response, positioning them at the forefront of decision-making and service delivery has been the focus of the Joint Team in part to help address stigma and discrimination and contribute to an enabling

environment for equitable access to integrated HIV services. However, the lack of an organized community-health strategy (now in preparation) has hampered a meaningful scaled contribution of the communities, CSOs, and key populations to both the HIV response and to achieving the third component of PHC—empowered people and communities.

The ability of the agencies to tap into their respective areas of expertise and the potential to engage multiple sectors in the HIV integration into PHC agenda was identified as the main added value of the Joint Programme, with scope for further strengthening across broader programme areas of each Cosponsor. However, the Joint Programme lacks the necessary resources to further HIV integration and interlinkages activities within the PHC, while simultaneously strengthening the PHC response in line with commitments to the government of Angola.

## Conclusions and considerations on the way forward

Opportunities exist within Angola to further advance on commitments laid out in the Luanda Declaration to strengthen both PHC and address HIV in a synergistic manner with the potential to not only benefit HIV outcomes but also broader health outcomes. That said, the benefits versus risks, versus trade-offs of such integration, including for key populations and other vulnerable populations and specific systems for health, need to be analysed and considered. The Joint Programme has produced numerous publications including guidelines, policies and strategies to support integration of services which are being employed in Angola in addition to co-location of services within primary care settings which can be built off. Opportunities for leveraging HIV/PHC intersections are vast but require clarity on integration models and approaches, political commitment, strengthening of data systems, coordination, and leadership, while ensuring a focus on social equity and health as a human right.

The following presents considerations for the Joint Team to further leverage HIV and PHC integration and interlinkages:

- Assist the government in developing a vision of how HIV assets and investments, including key lessons learned from the response which can inform PHC strengthening approaches, can contribute to achieving PHC objectives.
- Help identify champions for the integration of HIV and PHC.
- Assist the MoH, to reinvigorate the Inter-Agency Coordination Committee and ensure it represents a multisectoral and multi-stakeholder advisory group inclusive of private sector, with the ability to help inform the policy dialogue.
- Support strengthening of data systems, including to improve data quality and engage in joint data systems usage including a focus on improving data quality and integrating community led monitoring of PHC and HIV.
- Strengthen coordination and ensure that discussion around HIV and PHC interlinkages is an agenda point within the Joint Team meetings including highlighting relevant activities in other sectors.
- Engage in efforts to strengthen the Joint Team role and function to pre-COVID times under the guidance and leadership of UNAIDS working together with the UN Resident Coordinator's Office.
- Strengthen active and meaningful engagement of civil society in the areas of HIV-sensitive social protection and its integration within PHC.

# 1. Introduction and context

## 1.1. Purpose and scope of the case study

The purpose of carrying out country case studies under the independent global evaluation of the UNAIDS Joint Programme (Joint Programme) contribution to strengthen primary health care (PHC) and HIV integration and interlinkages, is to generate evidence on evaluation questions and learnings from the different ways in which the Joint Programme has supported countries to leverage PHC and HIV linkages across various contexts. The case studies explore the extent to which HIV responses are delivered through a PHC lens, how this is working in practice, and are expected to document the related achievements, challenges, risks, and opportunities. The country case studies also seek to explore the extent to which HIV investments have been leveraged for the best broader health outcomes and gains. The studies aim to provide suggestions on the way forward to accelerate and prioritise Joint Programme actions related to HIV-PHC interlinkages and integration.

Four countries were selected for the country case studies and include: Angola, Botswana, Indonesia, and Pakistan. The selection was based on criteria including relevance of evaluation topic for UNAIDS country offices, the UNAIDS Joint Programme and government, geographic diversity, and a diversity in HIV epidemiology and health system contexts.

## 1.2. Approach/methods/limitations

**Approach and methods** - The case study used a mixed methods approach combining qualitative and quantitative methods for data collection and analysis. An initial document and data review was supplemented by primary data collection through key informant interviews and focus group discussions undertaken during the period 4 June - 9 June 2023 with key stakeholders from the national and provincial levels (Benguela).

Key stakeholders were purposely selected to take part in key informant interviews and focus group discussions in order to collect relevant information and evidence at the national and provincial levels. Stakeholders interviewed represented individuals and groups from UN organizations, government (central, provincial, municipal Ministry of Health (MoH) representatives from the public health, HIV, maternal and child health, sexual and reproductive health and rights (SRHR) and other reprogrammes along with the National Institute for the Fight Against AIDS (INLS)), multi and bilateral organizations, community groups, civil society, health facility staff (semi-private and public sector) and private sector. In addition to conducting extensive interviews in Luanda the team visited Benguela, one of two provinces where UNDP carries out activities under the auspices of their work as the principal recipient of the current Global Fund integrated HIV/TB/malaria and RSSH grant in Angola.

Key informant interviews were conducted using a semi-structured interview guide that listed a predetermined set of questions related to the themes of this country case study. Informants in the focus group discussions were asked to reflect on the questions asked by the interviewer, provide comments, listen to what others in the group had to say and react to their observations. The interview guide/focus group discussion guide is available in Annex 1. Altogether, 20 key informant one-on-one interviews (in the case of JICA three persons attended; two persons attended from the UN Resident Coordinators Office), and 7 focus group discussions were conducted through which a total of 88 key stakeholders shared their experiences.

Data from key informant interviews and focus group discussions were recorded in notes, analysed, and organized according to themes and content. The evaluation relied on triangulation both across and within categories of data sources. Coding all qualitative data and populating the evaluation evidence matrix by sub-question and evaluation question supported the triangulation process.

**Limitations**—The country case study was restricted by time and scope to include relatively few informants and lent itself to learning and group discussions. However, key informants were carefully

selected to bring forward perceptions from a variety of stakeholders on the selected themes and learnings to be documented. The depth and breadth of information and exposure to critical actors in the HIV and PHC response provided insight into the efforts undertaken to plan for and respond to both the HIV and PHC agendas.

In addition, dedicated and concerted efforts geared toward developing a holistic PHC response appeared to be in their very early stages as witnessed by the development of the Luanda Accord in June 2022 which has gained little traction since. Additionally, purposeful HIV integration and interlinkages efforts have been pursued in areas, mainly initiated under the auspices of the donor community, including the prevention of vertical transmission of HIV, sexual and reproductive health (e.g. treatment and support; access to comprehensive sexuality education; pregnancy related services (and skilled attendance and delivery); STI and HIV prevention, diagnosis and treatment; prevention and gender-based violence and care for survivors of gender-based violence—however these are mainly integrated when UN agencies), paediatric diagnosis, and treatment as well as TB prevention, diagnosis and treatment long before 2000.

However, a comprehensive approach is limited and not clearly defined in a PHC strategy (e.g., not addressing comorbidities and coinfections other than e.g., TB and STIs, lack of a visibility life-course approach including for ageing PLHIV and beyond). In addition, the lack of integration of community-focused efforts and somewhat absence of or ad-hoc multisectoral response to HIV, which is a critical element to PHC, combined with only a “new” focus by government on PHC challenged the ability of the team to identify concrete efforts aimed at integration and interlinkages of HIV and PHC in Angola during the evaluation period.

Interpretation of report findings should take into consideration these limitations. Nevertheless, important learnings, opportunities and gaps are presented in this report, while considering potential for future directions.

## 2. Introduction to the Angolan national PHC and HIV context

### 2.1. Overview of health context

#### **2.1.1. Key demographic, socio-economic and burden of disease/health data**

Angola, located in Southern Africa, is one of the largest countries on the continent. According to projections from the 2014 Census, the country has 34 094 077 inhabitants in 2023, of which 51% are women and 20% are adolescents and youth between 15–24 years old. The Luanda Province, which houses the capital city, is home to almost 28% of the population. Administratively, the country currently has 18 provinces, 164 municipalities and 557 communes. Life expectancy in Angola is 63.1 years (2019). The top five leading causes of death among females are neonatal conditions, lower respiratory infections, HIV/AIDs, TB, and diarrhoeal diseases. The picture is slightly different for men with neonatal conditions, lower respiratory infections, TB, diarrhoeal disease and malaria constituting the top five.<sup>1</sup>

Approximately 47% of the population is under the age of 15 of which 20% are under the age of five. In addition, 20% of the population is between 15 and 24 years. This breakdown is of particularly relevance when considering the HIV and PHC response as it shows the extremely young nature of the population (67% aged 24 years and under). This, combined with high fertility rates (estimated at 6.2 births per woman), young age of sexual debut (15 for girls and 16 for boys; with 22.9% of girls and 34.8% of boys having had sex by age 15), low age of fist births with 38.4% of women having given

<sup>1</sup> WHO data. <https://data.who.int/countries/024>

birth by age 18, and 61.1% of girls aged 15-19 stating that they did not want their last pregnancy (more than or equal to two years) or did not want the pregnancy at all<sup>2</sup> points to the urgent and critical need to address the youth population with comprehensive services. This young population also creates challenges in terms of meeting the demand for the supply of social services, particularly in the health and education sectors. Additionally, generating demand for services is challenged by language and religious beliefs which impact on communicating behaviour change for the promotion and demand for health and well-being in general. There are more than 40 languages, 9 of which are predominant. With 50% of the population identifying as Catholic and 33% as Protestant, religious dogmas play a factor in prevention messaging including the debates on sexuality and other social issues that impact the response to HIV. Coupled with a 66% percent literacy rate, the challenges are notable.<sup>3</sup>

### **2.1.2. Progress on sustainable development goal 3 (SDG3) targets (except SDG3.6 and 3.9)**

Based on 2017 data from the National Institute of Statistics, only 2.3% of gross domestic product is allocated to the health sector which has contributed to less-than-optimal results. These include an under 5 mortality rate of 69 deaths per 1 000 live births (2021)<sup>4</sup> (main causes by order of gravity—diarrhoea, neonatal, other, pneumonia, malaria) and an unmet family planning rate of 43% among adolescent girls aged 15-19 as examples<sup>5</sup> and adolescent fertility rate of 138 per 1 000 women aged 15-19, 2021.<sup>6</sup> That said, a positive trend in infant mortality rates (from 140.3 deaths per 1 000 live births in 1980's to 48.3 in the 2000's),<sup>7</sup> has been recorded. Continuing high rates of maternal (222 deaths per 100 000 live births—2020)<sup>8</sup> partially associated with low ante natal care (ANC) rates -61% completing four pre-natal visits but with significant urban (74%) and rural (39%) differences<sup>9</sup>, child and youth mortality and a high incidence of infectious and parasitic diseases, in particular HIV (prevalence of 1.5% among adults—UNAIDS 2022 data), TB (incidence of 250/100 000 - 2020<sup>10</sup>) and malaria<sup>11</sup> are recorded. The National Health Development Plan 2012-2025 (PNDS) highlights that the problems faced by the National Health System are linked to the limitations of human, financial and material resources as well as the suboptimal use of the available resources<sup>12</sup>.

## **2.2. National PHC policy and programmatic response and challenges**

### **2.2.1. Current health sector strategic plan, universal health coverage (UHC) roadmap and PHC strategy**

The National Health System is divided between the public sector, for-profit and non-profit sectors, and the traditional sector and guided by government health programs, which aim to achieve UHC by 2025. The public health sector is structured at three hierarchical levels of the administrative system: central, provincial, and municipal. The public sector also includes health services provided by the Angolan Armed Forces, Ministry of the Interior and public companies such as Sonangol, Endiama, among others. The private sector, under the supervision of the Department of General Inspection of

<sup>2</sup> Contraception within the context of adolescents' sexual and reproductive lives: Angola Country Profile, World Health Organization 2020. Pages 1 and 2.

<sup>3</sup> VII Plano estratégico nacional da resposta ao VIH/SIDA, hepatites virais e outros infeccoes de transmissao sexual, 2023-2026, Pages 13- 14. (National Strategic Plan for HIV, Viral Hepatitis and other STIs)

<sup>4</sup> <https://data.worldbank.org/indicator/SP.MTR.1519.ZS?locations=AO>

<sup>5</sup> United Nations Common Country Analysis 2022: Angola, Page 40

<sup>6</sup> <https://data.worldbank.org/indicator/SP.MTR.1519.ZS?locations=AO>

<sup>7</sup> UN Common Country Analysis 2022. Page 40

<sup>8</sup> <https://data.worldbank.org/indicator/SP.MTR.1519.ZS?locations=AO>

<sup>9</sup> *ibid*

<sup>10</sup> <https://www.cdc.gov/globalhivtb/where-we-work/angola/angola.html>

<sup>11</sup> malaria accounts for 35% of curative care demand, 35% of mortality in children, 40% of prenatal mortality, 25% of maternal morbidity, and causes 60% of hospital admissions in children less than five years of age and 10% in pregnant women. USAID President's Malaria Initiative FY 2022 Angola Malaria Operational Plan.

<sup>12</sup> Plano Nacional de Desenvolvimento Sanitário 2012–2025, Pages 47 - 48

Health is more active in urban and peri-urban areas where the availability of public health services is limited or non-existent. The traditional sector is not regulated. The Angolan government has also made significant efforts to facilitate access to health services particularly in the construction and reconstruction of health infrastructure and the decentralization of the national health system, with emphasis on the “municipalisation of health services”. However, there are still concerns about the limited access to basic health services, especially in rural areas, due, among other reasons, to the insufficient resources allocated to the health sector and lack of prioritisation of community-based health services.

While Angola has made progress in UHC since 2000, there are still considerable challenges. According to WHO, the regional population weighted UHC service coverage index (SCI) was 46 in 2019, up from 24 in 2000. The UHC SCI is constructed from 14 indicators, extracted from various sources, and organized around four components of service coverage, as follows: 1) Reproductive, maternal, newborn, and child health; 2) Infectious diseases; 3) NCDs; and 4) service capacity and access. However, Angola’s SCI is between 39 and 43 since 2019, which is still in the lower range of the regional average. In addition to this, there is a significant gap in funding for PHC and catastrophic health spending (proportion of population spending more than 10% of their household budget on health out-of-pocket expenditures with Angola reporting are more than 0.1% increase in those spending over 25% of the household income on out-of-pocket expenditures) which is one of the highest in the region “which indicates that UHC falls short of meeting existing needs”.<sup>13</sup>

### **2.2.2. Leadership and responsibilities for delivering PHC at all levels**

Leadership for the delivery of PHC is highly hierarchical within the government structure where informants responded that municipalities and provinces have limited room to plan in line with their needs. At the Central level, Offices of the Minister and Secretaries of State constitute the Executive Bodies in support of the Head of State. At Provincial level, the Provincial Health Office provides for the administrative aspect of service delivery. Despite these designations, provincial health service providers still must seek support from the central entities. Consequently, at municipal level, the Municipal Health Directorates hold the mandate of the administrative health service delivery. However, for methodological/technical support, the service providers must seek support/approval from the Provincial or Central Offices.<sup>14</sup>

### **2.2.3. Community structures and engagement**

The existing community structures, both physical and operational, are more under the mandate of the Municipal Health Office, although the lowest level of government structure is the Commune, and it is at this level that most, if not all, community stakeholders engage to provide optimal response to the existing PHC needs.<sup>15</sup> The activities of the bilateral and non-governmental stakeholders have given birth to a variety of community health activists. Noteworthy of these are the Community Development and Health Agents (ADECOS) who are in the process of being absorbed into government structures and payroll under the Ministries of Health and Territorial Administration,<sup>16</sup> However, the idea of absorption of ADECOS into the government structure is not new and has yet to take place. According to informants they question when or if this will happen.

### **2.2.4. Role of private sector**

The lack of permanent institutions for multi-stakeholder participation and strategic communication has thwarted the private sector contribution to the achievement of the SDGs in Angola and this situation applies specifically to the role of the private sector in the delivery of PHC. In 2021, a survey

<sup>13</sup> United Nations Common Country Analysis 2022: Angola, Page 43

<sup>14</sup> National Strategic Health Plan in Response to HIV, Pages 18 to 21

<sup>15</sup> Ibid

<sup>16</sup> Um Futuro Sem VIH/SIDA: Plano Nacional de Prevenção da Transmissão do VIH, da Sífilis Congénita da Hepatite B da Mãe Para o Filho 2019–2022. 2018. Page 22



by UNDP and Price Waterhouse Coopers confirmed that there is great potential in and willingness to actively participate in achievement of the SDGs by various private sector entities, with 67% of those surveyed referring to SDGs in their reports, and 76% being aware of SDGs. The UN Global Compact is present in Angola mobilizing companies in different sectors to provide a framework for developing more sustainable and responsible businesses, in line with SDGs.

### **2.2.5. Health systems and service delivery challenges and social inequities affecting access to health services**

The bureaucratic factors of the hierarchical structures and the social, economic, cultural, and moral/religious influences on the Angolan society constitute the majority of the challenges and social inequities affecting access to health services. According to the DHS 2016 survey documented in the National Strategic Plan in Response to HIV, seven out of ten women in Angola reported at least one problem in accessing health care. Sixty three percent (63%) had difficulty getting money for counselling or treatment, and 52% had problems with distance to the health facility. Among women aged 20 to 49, about 29% said they needed permission to go to a health facility and 30% said they did not want to go to the doctor alone. One-third (34%) of women aged 15-49 and married at some point have experienced marital violence, either physically or sexually. A quarter (26%) of ever-married women had experienced spousal violence in the 12 months prior to the survey. About one-third of men and women aged 15-49 demonstrate discriminatory attitudes toward PLHIV. Prejudice continues to generate violence against PLHIV, as well as against people belonging to key populations (KPs), such as men who have sex with men, sex workers, and transgender people.<sup>17</sup>

## 2.3. Overview of the national HIV epidemic and response

### **2.3.1. Key epidemiological HIV data, trends, and data on KP groups vulnerable or affected by HIV, key geographies**

Angola has documented a general HIV epidemiological burden with an estimated prevalence of 1.5%,<sup>18</sup> considered as one of the lowest in the SADC sub-region with rural areas less affected than urban areas. The HIV epidemic in Angola is concentrated in urban areas; the provinces with the highest HIV prevalence were Cunene (6,1%), Cuando Cubango (5,5%), Moxico (4%), Lunda Sul (3,9%) e Lunda Norte (3,4%). Prevalence in the two provinces which receive Global Fund support through UNDP as the principal recipient, is 1.8% for Benguela, 1.6% for Kwanza Sul, and for the third Province (Bie) to be targeted under the new grant, the prevalence is 1.9%.<sup>19</sup> In 2022, there were 310 000 adults and children living with HIV in Angola with the number of new cases of HIV estimated at 15 000, compared to 20 000 in 2019.<sup>20</sup>

Groups particularly vulnerable and at risk of HIV include youth, pregnant women, members of the LGBTIQ+ community, displaced people, and sex workers. At national level, 49% of PLHIV adults aged 15 and over received antiretroviral treatment in 2022 up from an estimated 26% in 2017, whereas in the same period only 22% of children received treatment up from an estimated 9% in 2017.<sup>21</sup> Despite the positive development there is a need for urgent acceleration to approach the globally agreed target of 95% treatment coverage by 2025.<sup>22</sup>

Prevalence rates vary among KPs. The PLACE Study conducted in 2017 in Luanda, Benguela, Bié, Cabinda and Cunene provinces showed an HIV prevalence among female sex workers of 8% and a 2%

<sup>17</sup> National Strategic Plan in Response to HIV, Page 11

<sup>18</sup> <https://www.unaids.org/en/regionscountries/countries/angola>

<sup>19</sup> A rapid situation Analysis of Angola's HIV/AIDS Responds 2015-2020 in the Context of the 90-90-90 Targets. Joint United Nations Programme on HIV/AIDS Angola; 2021. Page 30.

<sup>20</sup> <https://www.unaids.org/en/regionscountries/countries/angola>

<sup>21</sup> <https://www.unaids.org/en/regionscountries/countries/angola>

<sup>22</sup> United Nations Common Country Analysis 2022: Angola, Pages 40 and 42

prevalence rates among gay men and men who have sex with men (MSM).<sup>23</sup> According to the National Reproductive Health Department data, it is estimated that pregnant women represent 5% of the population and the HIV prevalence in pregnant women according to the last sentinel survey carried out in 2013 is 2.2% in the 15–49 age group and 1.7% in young women between 15 and 24 years old. In total, 0.9% of young people aged 15–24 are HIV positive; the prevalence is higher in women (1.1%) than in men (0.7%). The prison population sampled for the HIV test in one of the prison facilities in Luanda in 2017 revealed a prevalence rate of 16.16% - although the sample was small (167 screened with 27 positive).<sup>24</sup>

### **2.3.2. The aims and strategic orientation of the new national strategic plan (NSP) (2023–2026), progress against 95-95-95 targets**

The VII National Strategic Plan for Response to HIV/AIDS, viral hepatitis, and other STIs in Angola, 2023–2026 (hereafter referred to as PEN VII or NSP) is based on principles of human rights and equity in health and is aimed at eliminating structural barriers that prevent the reduction of HIV incidence in all populations, especially the paediatric population, pregnant women, vulnerable populations, and KPs. This includes the mitigation of the social determinants that affect the epidemic including stigma and discrimination (S&D) and gender-based violence and calls for inter-ministerial collaboration and synergies with the private sector.

Representatives from the government, non-governmental organizations, the private sector, donors, multi and bilateral partners, education, public health, and civil society participated in its elaboration under the coordination of the INLS of the MoH.

One of the main limitations encountered in the preparation PEN VII was the lack of an updated Multiple Health Indicators Survey (IIMS) data (delayed in 2020 due to the restrictions imposed by the Covid-19 pandemic), limiting the analysis of the previous plan and the estimation of future targets. In order to better guide actions, a geographic prioritization was made that categorized the burden of disease by geographic area in order to inform the program management model at the central, provincial, and municipal levels.<sup>25</sup> Furthermore, the PEN VII calls on each province to actively take ownership of its programme, identifying its target groups, critical localities, and the type of service model to be adopted by municipality and/or district.

In order to strengthen and address the programme's financial deficiency, the PEN VII encourages the revitalization of old public-private partnerships and the formation of new partnerships between community-based organizations that include PLHIV networks, the private sector, local government, and communities. The plan also highlights strengthening the multisector involvement for implementation of the national plan as a key priority area and indicator however specific sectors are not indicated. In addition, community engagement is a theme throughout the plan and includes involving community organizations in activities ranging from training of community leaders to strengthening community-based testing, monitoring, prevention of mother to child transmission (PMTCT) and ART and strengthening related data reporting systems. With respect to integration, the plan focuses on integration of testing services with viral hepatitis and other STIs, in antenatal visits, and for HIV/TB services. Primary health care is mentioned however briefly and in relation to the Integrated Municipal Intervention Programme. That said integration of HIV into PHC is not mentioned in the plan.

<sup>23</sup> Um Futuro Sem VIH/SIDA: Plano Nacional de Prevenção da Transmissão do VIH, da Sífilis Congénita da Hepatite B da Mãe Para o Filho 2019–2022. 2018. Page 24 to 27

<sup>24</sup> Um Futuro Sem VIH/SIDA: Plano Nacional de Prevenção da Transmissão do VIH, da Sífilis Congénita da Hepatite B da Mãe Para o Filho 2019–2022. 2018.

<sup>25</sup> The 18 provinces were categorized using prevalence (IMMS 2016), incidence (Spectrum / Naomi, 2021), % PLHIV (IMMS 2016/INE), prevalence among women (IMMS 2016) and fertility rate (IMMS 2016). Bas on this scoring they were categorized by range including Priority 1 (speed up, intensify, reinforce joint morning, etc.; n=5), Priority 2 (Intensify, reinforce programmatic actions; n=6) and Priority 3 (accompany, suite the response according to programme actions; n=10).

### **2.3.3. Structural issues affecting vulnerability and access to key services (human rights, gender equality)**

There is an intimate link between human rights and HIV and its impact on people and communities around the world. Human rights, inequality, limited access to the enjoyment of fundamental rights and rights violations have played a significant role in the spread of HIV. Both the Angolan government and other stakeholders agree that there is need for more leadership and commitment in all aspects of the response to HIV/AIDS by the respective government entities and UN agencies as well as regional and sub-regional bodies.<sup>26</sup>

However there remains legal gaps and several barriers including the ability to ensure human rights for all. The recent Legal Environment Assessment conducted by UNDP found that while promising laws and policies protecting human rights with respect to HIV are in place, there are many challenges and gaps. These include punitive laws creating barriers to accessing services (e.g., the criminalization of exposure, non-disclosure and transmission of HIV which have been found to discourages people from seeking testing and adhering to treatment). Moreover, although there is an HIV law from 2004 it is outdated (e.g., lack of special protection for key and vulnerable populations and inclusion of sexual and reproductive health strategies and/or policies).

It is recognized that advances have been made in availability, accessibility and quality of services and information, yet challenges are still numerous in particular at the rural level. These include, amongst others, “health units are poorly maintained; health information materials, human and technical resources for health are limited with insufficient health personnel in rural and peri-urban areas; financial resources are inadequate and there are major problems related to the underlying and social determinants of health”<sup>27</sup>

Furthermore, stigma and discrimination for PLHIV and other KPs remains a significant impediment to achieving stated goals to address HIV and AIDS. In workshops organized by the INLS, the PLHIV and KP representatives (MSM, gay men, female sex workers, lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI+)) reported that health professionals constantly discriminate against them.<sup>28</sup> This was further confirmed in the recent Stigma Index 2.0 from 2022 which reported that 11% of PLHIV “suffered from any abuse of rights to PLHIV by health professionals” while 18% “suffered from some abuse of rights for being PLHIV”.<sup>29</sup> This demonstrates that stigma and discrimination against PLHIV is evident not only within the health facilities but amongst families, communities, within schools and from law enforcement . This was confirmed by informants, and even more challenging for KPs (LGBTQIs, sex workers and drug users) 70% of whom reported abuses and disrespect for the rights. These abuses can contribute to, amongst other things, a decrease in retention rates for those on treatment (according to the stigma index 42% of respondents to the survey interrupted treatment in the previous 12 months).

Other barriers are also prominent and present additional challenges to addressing the epidemic. For example, young people still experience many social, cultural, legal and policy barriers which affect their ability to access both HIV and SRHR services. This is particularly concerning considering the age demographics in Angola with 67% under the age of 24 (47% under the age of 15). For example, according to the law, young people under 18 require the consent of a legal guardian or parent to test for HIV.<sup>30</sup> Additionally, deeply engrained patriarchal practices and mindsets along with other cultural practices “often perpetuated in customary law” continue to drive gender inequality in Angola regardless of legal advances addressing gender equality. The HIV response, in tis strategies and

<sup>26</sup> Angola: Avaliação do Ambiente Jurídico para o VIH e o Direito à Saúde Sexual e Reprodutiva, Page 39

<sup>27</sup> Legal environment assessment for HIV and the right to sexual and reproductive health, Angola. UNDP. November 2020. Page 12

<sup>28</sup> Um Futuro Sem VIH/SIDA: Plano Nacional de Prevenção da Transmissão do VIH, da Sífilis Congénita da Hepatite B da Mãe Para o Filho 2019–2022. 2018. Page 37

<sup>29</sup> Stigma Index 2.0 Related to People Living with HIV in Angola, Study Report 2022. Table 28

<sup>30</sup> Note: the national Protocol on HIV Testing allows for exceptions for adolescents aged 15-18 where a counsellor considers them to have the ability to understand the test and the implications of the test result

policies, does not adequately address gender vulnerabilities of women living HIV. Additionally, the high level of illiteracy and low educational attainment beyond primary school level, more pronounced for women than men, presents as an impediment to service access.

Although health systems strengthening is not a clear priority of the PEV VII a guiding principle of the plan is “sustainability focusing on guaranteeing financial, material and human resources for the development of actions” including through the establishment of public private partnerships to further the sustainability of funding for programmes and actions. In principle the plan builds off of PEN VI including a prioritization of integration of services in high impact priority areas, and at the same time strengthening integration and systems strengthening actions to respond to outbreaks and pandemics with minimal disruption to services provided to PLHIV.

The plan highlights areas for integration but also weakness in integration that have hampered efforts for example the lack of integration between the Ministry of Education and the MoH creating a barrier for not promoting the issue of SRHR in secondary education and teacher training<sup>31</sup> and the weak integration of HIV and TB efforts with “71% of patients with TB were tested for HIV and received their results. Only 42% of PLHIV started TB preventive treatment and only 47% of co-infected patients were placed on ART (TB Report, 2021).”

## 2.4. HIV financing

### **2.4.1. Current financing for HIV and the extent to which HIV services are included in any UHC/health insurance system or health services packages.**

Regarding finances, more resources as well as more efficient use of resources is needed to get the response to the HIV epidemic back on track to end AIDS as a public health threat by 2030. There was a notable gap in financing of the PEN IV between 61%-75% over the four years (after the government contribution) for which the various international partners tried to fill the gap. For the PEN VII (2023–2027) Global Fund has allocated around USD 50 million to the HIV response for 2024 to 2027 while (US) President’s Emergency Plan for AIDS Relief (PEPFAR) has committed to USD 46.6 million for 2023–2025.<sup>32</sup> For Angola, significant investments are needed primarily in three areas: Primary HIV prevention, HIV testing and treatment, and strengthening community action. Angola has made great efforts to address the gaps and needs related to the response to HIV/AIDS, with partners funding about 22% of the ART commodity needs and the remainder covered by domestic funding. That said, according to informants a large percentage of the domestic health budget goes unspent so there is a call for more efficiency with clear programming and linkages to the state budget.

Private health insurance in Angola covers 4% of women and 9% of men aged 15–49 and is higher in urban areas, for both men and women (12% and 5%, respectively), than in rural areas (2% against 3%). On the other hand, access to health insurance increases with the level of education and socioeconomic status, in both women and men. By level of education, it ranges from 3% in women with no schooling to 7% of women with secondary or higher education.<sup>33</sup> It is important to note that these trends are exclusively representative of workers under the private sector, bilateral, multilateral, and other stakeholders as a public sector health insurance scheme does not exist and the majority, if not all, of the informal income earners are not included.

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<sup>31</sup> PEN VIII. Page 25

<sup>32</sup> Um Futuro Sem VIH/SIDA: Plano Nacional de Prevenção da Transmissão do VIH, da Sífilis Congénita da Hepatite B da Mãe Para o Filho 2019–2022. 2018. Page 59

<sup>33</sup> Relatório Final do Inquérito de Indicadores Múltiplos e de Saúde 2015-2016. Page 62

## 3. Introduction to the UNAIDS Joint Programme strategic orientation and approaches

### 3.1. Joint Programme and Joint Plans overview of the strategic direction and priorities and how they are responding to country needs and gaps

When examining the HIV response, limited human resources for health (both by numbers and technical skills) at health facility level to adequately provide quality services, lack of baseline treatment data to inform target setting, and perceived stigma and discrimination are critical gaps in programming. Weak linkage to care and treatment after a positive diagnosis, limited strategies for retention in care and treatment adherence, and commodity supply instability are additional gaps. All of these areas have been targeted, although not to scale, by the Joint Programme since 2000.

The 2020–2021, under the much appreciate leadership of UNAIDS, the Joint UN Plan was built. The plan was grounded in the successes under the previous biennia and was informed by stakeholder consultations and further analysis of data gaps presented above in order to select strategic priority areas. Areas selected included scaling up of the Test and Treat initiative, accelerating PMTC efforts based on the use of evidence, attention to gender and human rights programming to close the gap in prevention among KPs and in strategic locations in addition to tackling adherence issues in relation to ART. Efforts also continued to focus on strengthening data reporting systems (namely the DHIS2) with an eye to integration of key HIV activities.

For 2022–2023 the strategic areas supported, in addition to existing ongoing areas of strategic focus, include HIV testing and treatment, strengthening integration of SRHR and HIV services in ANC, elimination of mother-to-child transmission, male partners engagement in PMTCT, advocacy to close treatment gaps, facilitate access to HIV prevention and SRHR services in humanitarian settings, engagement of municipalities leadership to promote rights-based approach for HIV response, adherence to ART and capacity building of health professionals on HIV prevention and treatment guidelines.

The catalytic support being implemented by the Joint Team is done in partnership with INLS, the civil society organizations (CSOs) and Direção Nacional da Saúde Pública—National Directorate of Public Health (DNSP).

The Joint Teams commitment to and alignment with the national HIV, viral hepatitis and STI response, coordinated by UNAIDS, is evident through its continual support to help guide the country, based on international standards, policies and guidelines on a comprehensive response to HIV. Importantly this includes both technical and financial support to the planning and production of the last three national strategic plans in addition to a plethora of treatment, care and prevention guidelines. The support to the development of the national strategic plan (PEN VII) includes scenario building at national and provincial level, requested by INLS, which will commence in late 2023.

### 3.2. Overview of Cosponsors main activities and funding as per Joint Plans from 2020-2023

The following table presents overview of the Cosponsors, along with the Secretariate, involved in the Joint Programme in Angola since 2020 and their main activities and level of funding. Data presented in the table was taken from the JPMS (extract date 2 June 2023) and represents planning of both activities and funding levels rather than actuals. Therefore, some variation, particularly with respect to financing, is expected. Of note is the lack of language and specific focus around support to PHC and UHC, inclusive of health financing, although implied through efforts targeting ANC, paediatric, SRHR and TB services, the focus on empowering and engaging with people and communities and looking at the broader determinants of health including the legal environment and education sector.

**Table 1: Unified budget results and accountability framework (UBRAF) financing by agency, activity, and year (2020-2023)**

Co-sponsor	Activities	2020 US\$	2021 US\$	2022 US\$	2023 US\$	Total
UNAIDS	Advocate for scale up of “Test & Treat” strategy and TB screening among PLHIV, HIV testing and counselling at ANC; strengthen partnership and networking with Global Fund and PEPFAR; develop rights-based materials for prevention among youth; train CSO representatives to promote access and adherence to ART; HIV and social protection assessment; technical assistance for generation and utilization of data at national and sub-national level; support development of HIV financing and sustainability plan; HIV gap analysis and development of citywide plan; CSO strengthening for reporting, adherence, and addressing KP needs	113 000	48 000	30 000	16 000	207 000
WHO	Capacity building health professionals to implement HIV treatment guidelines; review current/develop new NSP; training health care workers in task shifting and integration of SRHR and HIV testing in ANC sites; complete data gaps and support community health workers in TB screening for PLHIV; train staff in logistical information system; strengthen integrated health management system—training INLS/MoH	204 370	60 990	70 254	49 178	384 792
UNICEF	Strengthen primary HIV prevention, implement elimination of mother-to-child transmission plan, early infant diagnosis (EID), Male partners involvement in PMTCT, Implement Innovative HIV testing strategies, train providers on HIV testing at ANC, HIV and social protection assessment; support training/use of DHIS2; review, oversight, monitoring of integrated strategies and plans for SRHR and HIV; support to EID and point-of-care plans; bottleneck assessment of PMTCT/EID and promote integrated ANC and PMTCT services; Assist in development of “born free to shine” initiative; with UNDP build capacity of CSOs for PMTCT at community level; testing and monitoring children born to HIV+ mothers, quality improvement of integrated management of ANC/PMTCT/EID; advocacy engagement	281 766	73 295	82 486	58 040	495 587
UNFPA	Support health facilities and PLHIV networks to strengthen referral, linkages among PLHIV to improve adherence to ART treatment in Luanda; Strengthen referral, linkages among PLWH to improve adherence to ART in Luanda city, train peer educators to prevent and test for HIV among KPs, conduct size estimate of sex workers, strengthen provision of HIV and SRHR services among young and youth, train teachers of Luanda City on implementation of comprehensive sexuality education (CSE); awareness raising for prevention among KPs and LGBTQI, prisoner for HIV testing and counselling; engage CSOs and build skills for prevention activities targeting youth; training SRHR health workers on HIV integration; technical assistance for CSE primary and secondary school curricula; conduct of a situational analysis in prisons; targeted HIV self-testing and referral to care among KPs and prisoners	147 716	53 190	109 260	65 982	376 148
UNDP	Train providers and CSOs in human rights-based and results oriented to PMTCT, address S&D and promote HIV prevention, access ART and retention in care, municipal leadership on human rights-based approach and adherence to ART, use of gender assessment to improve delivery of HIV and SRHR services, increase domestic financial resources for HIV response; technical assistance for implementation of the Action Plan related to 2018 HIV legal environment assessment; specialised training to CSOs on treatment adherence and linkages; development of mobile solutions to scale up ART and retention care; conduct of stigma index; policy support to increase access of young KP to SRHR services; capacity building to national network of AIDS service organization (ANASO); support to health management information systems including training and technical meetings	247 536	156 600	72 000	54 300	530 436
UNHCR	HIV response in humanitarian settings; Friendly testing and treatment services among refugees; sexual and gender-based violence prevention through information campaigns	62 888	42 174	30 000	21 000	156 062
		<b>1 057 276</b>	<b>434 249</b>	<b>394 000</b>	<b>264 500</b>	<b>2 150 025</b>

### 3.3. Main partnerships engaged in implementing the Joint Plans, number of activities targeting integration of HIV and PHC

The Joint Team in Angola collaborates with national (government and non-governmental organizations including CSOs and private sector organizations) along with other international partners (Global Fund, PEPFAR (USAID, CDC, US State Department) JICA, EU and others) to support the planning, development, and implementation of the nationwide HIV responses and integration of activities into PHC.

The main governmental partners with whom the Joint Team is engaged include the MoH as the major stakeholder represented by the National Institute for Public Health and the INLS. The Joint Team also works with various ministries and across different sectors from education, gender, health, social action and family and women's promotion, youth, economy and planning, justice and human rights, statistics, finance, civil society, and religious affairs. The Joint Team has provided both financial and technical support, increasingly focusing on technical support, to these governmental entities often through contracted specialists who conduct targeted pieces of work (e.g., development of a policy, strategy, or guidelines; capacity building workshops and trainings). Technical specialists/contractors serving as staff members of the Cosponsors also engage with the various ministries (e.g., WHO normative guidance support for establishing treatment guidelines including for HIV self-testing).

CSOs are engaged in programmes and interventions at a more grass roots level with a focus on building the capacity of communities, KPs and linking communities to services. The Joint Team works closely with ANASO and its members. These CSOs are often the recipients of capacity building efforts conducted by technical specialists contracted by Cosponsors. There are also contracted implementing partners carrying out critical work at the community level (e.g., subgrantees under the Global Fund HIV grant implemented by UNDP as the principal recipient—although this funding is outside of UBRAF).

The US government has been a collaborator in several initiatives through its agencies—Centers for Disease Control, Department of Defence, and USAID. The support provided by the Joint Team on pre-exposure prophylaxis, self-testing, condom promotion and the UNAIDS country office's facilitation of government support was appreciated by PEPFAR, as was the work by WHO on treatment modalities and UNICEF on PMTCT, adolescents and social campaigns. The Global Fund is an important donor to the HIV/AIDS response and as such represents a key partner. Global Fund has committed to strengthening health systems (focusing on health management information systems, procurement and supply management, financial management and human resources for health including a focus on strengthening community health systems) and integration as witnessed by their joint HIV/TB/malaria and health systems strengthening grant (currently implemented by UNDP).

Below are examples of integration-focused activities engaged in during 2022, this is not an all-inclusive list.<sup>34</sup> Other examples are included in the findings section which follows.

- 261 LGBTQI were reached with a comprehensive package of SRHR;
- UNAIDS, together with UNICEF and WHO as technical leads, supported the MoH and the INLS to set up a multisectoral technical team to lead the Global Alliance in Angola;
- UNAIDS engaged in the Social Protection Development Partners work with UNICEF, ILO, WFP and WB and shared the HIV sensitive social protection mapping done in 2021 to inform the advocacy around strengthened social protection for PLHIV in Angola;
- UNAIDS supported the Scouts association, 31 Kambas young community leaders in Cuanza Sul, Cuanza Norte, Uige and Luanda, through training in comprehensive SRHR;
- the Medical Club (CSO) provided comprehensive health assessments and services, HIV testing and referral to treatment to 237 female prisoners with support from UNAIDS. This work informed the

<sup>34</sup> Angola Country Agency Achievement Report 2022, JPMS extract from 2023.

joint work with UNFPA and UNODC engaging prison services to address the ongoing comprehensive health including nutritional needs of prisoners across Angola;

- UNDP supported the work of an organization of women living with HIV (Mwenho) who sensitized 187 pregnant women to the benefits of ANC and PMTCT;
- 97 transgender, 80 community leaders and 177 LGBTQI+ people were empowered in terms of shelter, psycho-social support, sexual and reproductive health and HIV/AIDS messaging and services.
- 65 health providers trained to improve the access of adolescents to integrate HIV and adolescent SRHR services;
- The following GBV services were available to refugees through UBRAF funding - wound care, presumptive treatment of STIs, post-exposure prophylaxis for HIV, pregnancy testing, vaccination for tetanus and counselling services;
- UNICEF provided technical and financial support for the expansion of adolescents youth friendly services and trained 50 health providers, to provide sexual, reproductive, maternal, mental health, HIV, GBV, and nutrition services to adolescents in 20 municipalities of Lunda-Sul, Bie and Huambo provinces;
- A total of 130 health providers trained on the new paediatric treatment regime (DTG) and HIV treatment guidelines;
- UNICEF provided technical and financial support to the MoH for the development of the National Community Health Policy to help establish a robust and sustainable community health structure that contributes to universal access to health care; and
- WHO also supported the INLS to conduct training of 30 health workers in Tuberculosis prevention among PLHIV in Luanda.

The above activities have a focus on the interlinkages and integration of HIV into PHC services although on a relatively small and geographically limited scale.

## 4. Findings

It is imperative to preface this section of the report by reiterating that PHC remains limited and constrained by many factors including the socioeconomic determinants of health which have a more notable effect on key and vulnerable populations. A specific PHC strategy that focuses on the three components of 1) integrated services with an emphasis on primary care and essential public health functions, 2) empowered people and communities, 3) multisectoral policy and action does not exist.<sup>35</sup> With respect to the second pillar, there is a notable lack of a formally recognized community health worker system to improve access to, and provision of, HIV services in addition to a lack of health care workers at the facility levels. ADECOS<sup>36</sup>, community development and health agents, focus mainly on malaria and do not support community interventions on HIV and TB. Efforts that do exist include community-based activists funded through community-based organizations and non-governmental organizations who operate primarily with funding from the Global Fund and/or PEPFAR as an example.

Additionally, there is no strategy or approved plan for integration of HIV with other programmes such as reproductive health, maternal, new-born, child and adolescent health and STIs—the exception being the Ministerial Decree of 2018 formalising the integration of HIV and TB.<sup>37</sup> Angola reports on HIV/TB integration efforts but as previously stated in the PEN VII the linkages are not

<sup>35</sup> Operational Framework for Primary Health Care Transforming Vision into Action, Technical Series on PHC, WHO 2020. Page XIII

<sup>36</sup> A policy for the use of ADECOS was developed in 2015 however it mainly targets malaria activities and is funded by the EU.

<sup>37</sup> Global Fund HIV, TB, Malaria and RSSH Funding Request Form, Allocation Periodo 2020-2022. November 2019



considered strong and indicators are not achieving targeted results (e.g. only 42 % of PLHIV have started TB preventive treatment and only 47% of coinfecting TB/HIV patients were put on ART).<sup>38</sup>

Given the “gap” in addressing PHC and its critical components, many of the findings are forward looking, taking into consideration ongoing integration efforts of the Joint Programme and how they can be capitalized on in the future to push forward an integrated HIV and PHC agenda. That said there is a need to rationalise whether further integration of a well-supported HIV response into a weak PHC systems is the right strategic direction, a discussion to be had within the Joint Team and the larger HIV community.

#### 4.1. EQ1: To what extent is there conceptual clarity and internal coherence within the Joint Programme (WHO, UNICEF, UNFPA, World Bank, and the Secretariat) and external coherence with other actors in relation to leveraging HIV and PHC integration and linkages?

##### SUMMARY OF FINDINGS – EQ1

- Although the merit of integration, alignment and interlinkages between HIV and PHC is recognized by the individual Joint Team agencies, conceptual clarity on what the Joint Programme aims to achieve is less clear. However, individual agencies are designing and engaging in HIV activities that are integrated within PHC settings in line with global guidance including monitoring progress against set targets.
- In addition to addressing HIV, the UN agencies design and implement programmes that address the broader social determinants of health including social, economic, and environmental factors in different sectors. This presents further opportunities to strengthen PHC and HIV integration across broader programme areas of each cosponsor.
- As UNAIDS leadership is re-energised following coordination challenges experienced during COVID-19, there is increasingly better collaboration and engagement at a technical level among Joint Team members.
- The Joint Team has served a critical role in assisting with conceptualisation of the most recent, as well as the past three, national strategic plans (PEN VII) which reflects integrated service provision for three diseases in line with the tenants of PHC yet lacks a clear focus on PHC.
- The national governments commitment to PHC has recently gained momentum with the signing of the Luanda Declaration on PHC and immunisation and even more recent development of a PHC financing action plan, however the financing of specific disease service delivery and systems is not described. This momentum provides an opportunity to strengthen PHC and HIV integration.
- There is lack of clarity (by all stakeholders) and emphasis concerning HIV integration efforts within the PHC agenda including critical functions that focus on the continuum of care from comprehensive prevention of HIV to adherence and care, and importantly the health workforce and the community response. Agencies, donors, and government acknowledge, and make concerted efforts to strengthen primary care as an interface between testing/diagnosis, treatment, chronic care for PLHIV and attempt to do so in a harmonized and complementary fashion, although more work is needed.
- The two major funding partners for the HIV response in Angola, Global Fund and PEPFAR, are aligned with the Joint Programme HIV and PHC integration activities, not least of all as UNDP serves as the principal recipient, with potential for further alignment and agenda setting.

<sup>38</sup> A Rapid Situation Analysis of Angola’s HIV/AIDS Response 2015-2020 in the Context of the 90-90-90 Targets, 2021. Page 33

#### **4.1.1. What does the Joint Programme aim to achieve through strengthening HIV and PHC alignment, integration, and interlinkages? To what extent is there conceptual clarity?**

**Although the merit of integration, alignment and interlinkages between HIV and PHC is recognized by the individual Joint Team agencies, conceptual clarity on what the Joint Programme aims to achieve was less clear. However, individual agencies are designing and engaging in HIV activities that are integrated within PHC settings in line with global guidance including monitoring progress against set targets.** Strengthening of HIV and PHC alignment, and further efforts aimed at UHC, is not a stated strategic priority of the Joint Programme. Although the Joint Team unanimously agrees on the relevance, and necessity, of HIV integration and interlinkages and that elements of the current HIV response clearly intersect with improving PHC, this is not explicitly reflected in the Joint Plan nor regularly discussed during Joint Team meetings. It is however notable that the Joint Programme activities include HIV integration with TB, viral hepatitis, STIs, SRHR and maternal and child health, for which they report in the JPMS, and which warrant consideration in the effort to strengthen PHC from a service provision (primary care provision and strengthening including training and referral systems) perspective. In addition, strengthening of PHC is an explicit focus within the UN Sustainable Development Cooperation Framework (UNSDCF 2024-2028) constituting a commitment to the government of Angola. This commitment may serve as an impetus for a more focused and strategic effort in future planning exercises of the Joint Programme.

**In addition to addressing HIV, the UN agencies design and implement programmes that address the broader social determinants of health including social, economic, and environmental factors in different sectors. This presents further opportunities to strengthen PHC and HIV integration across broader programme areas of each cosponsor.** For example, in addition to UBRAF funded activities, UNPFA has been active in humanitarian response activities and the education sector, UNICEF provides cash transfers to families and supports nutrition and water, sanitation and hygiene activities, the World Bank (although not funded under the Joint Programme) focuses on basic social protection, health system strengthening and creating fiscal space while UNDP engages in sexuality and gender programming including through regional programmes. Tapping into these potential integration linkages with a PHC perspective in mind presents an opportunity for the Joint Programme, through strengthened coordination by UNAIDS, to develop a more holistic and informed approach to integrating HIV in a meaningful way.

#### **4.1.2. To what extent are relevant goals, plans, strategies, and activities harmonised and aligned internally within the Joint Programme at country levels?**

**As UNAIDS leadership is re-energised following coordination challenges experienced during COVID-19, there is increasingly better collaboration and engagement at a technical level among Joint Team members.** Coordination and alignment are not necessarily reflected in the current Joint Plan as a vast majority of the activities focus on testing and treatment and the level of analysis and systematic thinking that went into the design and planning of the 2022-2023 plan was not sufficient according to informants. This is particularly concerning as the 2022-2023 plan is similar to that of the previous biennia. However, primary care integration-focused activities of the Joint Team members, including TB/HIV, PMTCT and ANC, HIV and SRHR (STIs, hepatitis, etc.) are aligned with joint collaboration in development of policies and guidelines for the country. In addition, the activities are aligned with government plans (which are often developed with financial and technical support of the Joint Team members) which in turn are in synch with international standards. The level of coordination and depth of technical discussions is reportedly improved following the appointment of the new UNAIDS Representative in late 2022 and the recruitment of news staff as part of the UNAIDS team.

#### **4.1.3. How does the Joint Programme’s work on HIV and PHC integration and linkages complement and harmonise with the efforts of national governments and external actors?**

The Joint Team has served a critical role in assisting with conceptualisation of the most recent, as well as the past three, national strategic plans (PEN VII) which reflects integrated service provision for three diseases in line with the tenants of PHC, yet it lacks a clear comprehensive focus on PHC. The strategy is based on a coordinated approach to diseases that share major commonalities including HIV, viral hepatitis and STIs in an integrated manner with a common vision for all three. It has common actions across systems strengthening, service integration, community engagement, amongst others all of which are in line with the objectives of a PHC approach.

**The national governments commitment to PHC has recently gained momentum with the signing of the Luanda Declaration on PHC and immunisation<sup>39</sup> and even more recent development of a PHC financing action plan, however the financing of specific disease service delivery and systems is not described.<sup>40</sup> This momentum provides an opportunity to strengthen PHC and HIV integration.**

Although a PHC strategy does not exist in the country, the MoH along with provincial governors, municipal administrators, health technicians and representatives of civil society agreed in June 2022 to the Luanda declaration of PHC and immunisation (referred to as the Luanda Declaration) elevating the PHC agenda as a critical step to ensuring UHC. The development of the declaration was supported by the Joint Programme (namely by WHO, UNICEF and UNAIDS) who provided both technical and financial support to push forward the agenda. The plan highlights the need to “strengthen the National Health System by improving governance mechanisms that are community-based, people-centred and capable of delivering quality health care on an ongoing basis, supported by an efficient and committed health workforce, adequate infrastructure, as well as sufficient and sustainable funding, thus ensuring universal access to health services without leaving anyone behind”.<sup>41</sup>

Subsequently, a PHC financing action plan was developed by a government delegation<sup>42</sup> as part of the PHC financing forum for Eastern and Southern Africa organized by UNICEF (21-23 March 2023, Rwanda). In principle, the government has committed to 1) improving the monitoring and evaluation systems for PHC including digitalized health information systems, 2) building capacity of PHC managers and strengthening the public financial management system to promote transparency, 3) increasing domestic funding sources and 4) developing a costed PHC policy and strategy by December 2023.<sup>43</sup> Critical to the action plan, as noted by informants and documentation, is increasing financing for PHC and reducing out of pocket payments which at present is a main source of health care financing in Angola. Also of note is that the vast majority of the actions are ambitiously scheduled for late 2023 through 2024. Details of how to carry forward the financing action plan and engage further in PHC including a roadmap for next steps beyond financing is pending.

Despite development of the financing action plan, key informants did not mention its existence during the course of interviews. It is unclear if this plan has been finalized and fully endorsed by the Public Health Directorate despite their authorship.

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<sup>39</sup> Luanda declaration on primary health care and immunisation in the Republic of Angola: National commitment for children and women’s health and the fight against the great diseases, Ministry of Health, Government of Angola. June 2022

<sup>40</sup> The plan was developed as part of the Primary health care financing forum for eastern and Southern Africa held in Rwanda (March 2023). That said informants did not mention this roadmap during interviews, rather it was shared by the Joint Programme following the evaluation visit. It is unclear if this plan has been fully endorsed by the Public Health Directorate. The vast majority of the action are scheduled for later 2023 and 2024.

<sup>41</sup> Luanda declaration on primary health care and immunisation in the Republic of Angola: National commitment for children and women’s health and the fight against the great diseases, Ministry of Health, Government of Angola. June 2022, p.4

<sup>42</sup> The delegation included Dra. Helga Reis Freitas –MoH/National Public Health Director, Dra. Sara Freitas –MoH/Secretary General and a representative of the Ministry of Finance

<sup>43</sup> These are highlighted actions, in total 23 actions are defined in the plan with clear responsible entities, timelines and identification of assistance needed from the Cosponsors

**There is an overall lack of clarity (by all stakeholders) and emphasis concerning HIV integration efforts within the PHC agenda<sup>44</sup> including critical functions that focus on the continuum of care from comprehensive prevention of HIV to adherence and care, and importantly the health workforce and the community response.** In Angola the HIV response, and existing integration efforts, have traditionally focused on those most severely affected by HIV through provision of acute care, including for those with HIV/TB co-infection or other co-infections (e.g., STIs, viral hepatitis) and maternal and child health services; a bio-medical intervention focus. This medicalisation of health jeopardizes the broader preventive and whole-of person approach to strengthening PHC with less attention to the continuum of care (from comprehensive prevention of HIV, to testing, treatment, adherence and care) going beyond the biomedical approach across sectors and programmes. Therefore, significant work needs to be done to address a more holistic approach to integration and PHC with attention to the multisectoral aspects and community/people empowerment. To that extent, informants expressed the urgent need for defining governance systems, ensuring financing and policy frameworks and integrated strategic information systems for PHC so that integration can be optimised—some aspects of which are highlighted in the above mentioned PHC financing action plan. Critically, the linking of access to social services which address poverty and social inequalities with a community focus is lacking and yet essential to progress the integration agenda.

**Agencies, donors, and government acknowledge, and make concerted efforts to strengthen primary care as an interface between testing/diagnosis, treatment, chronic care for PLHIV and attempt to do so in a harmonized and complementary fashion, although more work is needed.**

Despite the lack of a harmonized strategy for PHC and notably the absence of a community response strategy<sup>45</sup>, agencies and donors continue to push the integration agenda among themselves and with government, however from a more primary care perspective than a multisectoral policy and action and people/community centric approach. However, UNDP, as the principal recipient of the HIV Global Fund grant has made concerted efforts in the ongoing combined HIV, malaria, TB and resilient and sustainable systems for health (RSSH) grant, to expand the Government’s initiative to strengthen community health, which has been lacking as a structure in the PHC response. This is done in part through strengthening the networks of community health workers including ADECOS and “activistas” (see Section 4.3.1)

In June 2022 MoH (MINSa) and its strategic partners, established the Inter-Agency Coordination Committee which is meant to include UN agencies, international organization, and civil society. The committee pledged to support and measure progress against the PHC agenda. Despite recognition that the that “the cooperation mechanism with health partners provides an opportunity to evaluate actions, identify challenges, present commitments, and reinforce implementation<sup>46</sup>”, key informants stated that this coordination mechanism is not functioning optimally which is seen as a missed opportunity.

With respect to monthly Health Partners<sup>47</sup> meetings, to which government are invited but are reportedly not attending on a regular basis, discussions around the PHC and UHC agenda are frequent. The Health Partners were also active in helping develop/review the Luanda Declaration and establishing a technical working group to follow-up on actions needed to operationalise the Declaration. As part of the technical working group UNICEF, together with WHO assisted the DNSP with analysis of baseline and progress indicators.<sup>48</sup> This technical working group presents an opportunity to ensure that lessons learned from integration of HIV efforts, in addition to further integration efforts, are well communicated and taken into consideration when moving forward with the PHC agenda.

<sup>44</sup> HIV is only mentioned with respect to reducing under five mortality and coverage of ART in ANC.

<sup>45</sup> A draft community health care strategy is currently being circulated for approval – the first of its kind in Angola.

<sup>46</sup> <https://www.afro.who.int/countries/angola/news/angola-strengthens-partnerships-accelerate-primary-health-coverage>

<sup>47</sup> Health Partners Group includes WFP, UNICEF, WHO, UNFPA, UNHCR, Global Fund, USAID, CDC, World Bank, EU, UNAIDS, Instituto Camões, ACNUR, PAM, JICA

<sup>48</sup> 19<sup>th</sup> Health Partners Meeting (26 January 2023); 20<sup>th</sup> Health Partners Meeting (23 February 2023)

**The two major funding partners for the HIV response in Angola, Global Fund and PEPFAR, are aligned with the Joint Programme HIV and PHC integration activities, not least of all as UNDP serves as the principal recipient, with potential for further alignment and agenda setting.** The Global Fund strategy, 2023-2028, calls for a departure from disease specific siloes to a focus on resilient and sustainability systems for health with communities as the critical element in the health system on the road to UHC while acknowledging the role of primary health in achieving UHC. This is evident in the latest Global Fund applications which were joint HIV/TB/malaria/RSSH funding requests which include a more integrated approach to outreach and service provision for the three diseases and systems strengthening in two targeted provinces, Benguela and Cuanza Sul.<sup>49</sup> The funding requests conceptualised with the leading support of UNAIDS and other Joint Programme agencies assisting working together with government, civil society, private sector, other multi-bilateral organizations, etc.

The strategy for PEPFAR has similarly changed to focus on PHC and integrated planning. Through the continued coordination of the Global Fund and PEPFAR activities, where according to informants coordination and collaboration are notable in order to avoid duplication, an opportunity exists to influence the PHC agenda through the integration of systems and services established under their respective HIV responses. These include but are not limited to laboratory services, procurement, and supply chain management systems, monitoring and reporting systems, community activists and beyond. The integration of these well-established mechanisms, some of which is already happening, could help in establishing a holistic and well-functioning PHC government led effort.

UNAIDS is promoting increased engagement of the Cosponsors with PEPFAR and the sub-recipients of the Global Fund as well as Global Fund headquarters staff, engaging in discussions around HIV integration and interlinkages with PHC. This was evident in the role the Joint Team played in discussions around production of the Global Fund Funding Request as well as discussions around the Country Operational Plan for PEPFAR. According to informants there is continued opportunity to enhance these relationships and further the integration agenda through the Health Partners meetings.

#### 4.2. EQ2: To what extent is the Joint Programme applying the PHC approach to HIV responses and what are the achievements and lessons learned?

##### SUMMARY OF FINDINGS – EQ2

###### Key achievements of Joint Team

- Under the auspices of UNICEF, the Joint Programme has helped strengthen the integration of SRHR and HIV services through reviewing, providing oversight, and monitoring of integrated strategies and plans in addition to supporting PMTCT and early infant diagnosis within ANC settings.
- WHO serves a critical role in developing and disseminating normative guidance and subsequent training of health care providers as well as exerting its convening power around critical issues including HIV interlinkages and integration in PHC.
- Promotion of prevention among KPs through engagement of communities and civil society, along with an emphasis on SRHR and HIV integration through comprehensive sexual education comprise the majority of UNFPA activities as part of the Joint Programme efforts.
- Key achievements of UNDP contributing to HIV and PHC integration include engaging communities and KP groups to combat stigma and discrimination, treatment adherence efforts and technical and financial support to INLS for the conduct of the stigma and discrimination Index 2.0 survey.

<sup>49</sup> This subnational approach, new to the 2021-2024 implementation period will be expanded to include one additional province under the new grant for which the funding request is presently under consideration.

- UNAIDS has played a critical role in supporting the generation and analysis of data and its use to better inform the national strategic plan and its subsequent programme implementation, coordination of efforts across the spectrum of the HIV response, and in its work on empowering civil society to respond to the HIV needs of communities and KPs.

#### **Building political will for financing**

- The capacity of the Joint Programme to engage its leadership, advocacy and policy dialogue expertise to influence donor and government commitment and financing for HIV has been acknowledged by government and future support identified.

#### **Some of the identified barriers to integrating HIV into PHC include:**

- Guiding strategy and operational plan- Lack of a clear actionable PHC strategy and business plan is seen as a barrier however the political will to engage in discussion is seen as a potential enabler.
- Human resources - Capacity exists at the central level to help ensure integration of HIV into a PHC response and vice versa, noted by the many policies and guidelines that speak to different forms of primary care integration and to a lesser degree community-based integration. However, lack of capacity (in terms of education and sheer numbers) to ensure integration and assume a holistic PHC response that demonstrates impact at the municipality level is compromised.
- Community response—Investment toward a coordinated and strong community response, a basic pillar of a successful PHC response has been lacking, however a draft community-based health care response strategy is currently being circulated.
- Social services—Access to “basic” social services is a major stumbling block to ensuring a whole of society approach to PHC.
- Data quality—There is general apprehensiveness regarding the lack of quality and availability of data which is considered a significant threat to planning for integration of services.
- Stigma and discrimination and lack of an enabling environment to mitigate its impact—In line with the results of the stigma index and information from informants it is acknowledged that the less than favourable enabling environment for KPs plays a role the use of primary care and HIV related health services.
- According to informants both a lack of coordination and siloed working style of the Joint Programme coupled with a perceived focus of meeting individual agency/organizational targets (beyond the Joint Programme) are potentially jeopardising HIV integration and PHC strengthening opportunities.
- Ministerial coordination—Weak coordination capacity of the MoH, cited in the literature and by informants, is hampering not only integration efforts but the health care response in general.

#### **Some of the identified enablers/potential enablers to integrating HIV into PHC include:**

- Champions for the response—The First Lady’s initiative, which the Joint Programme assisted in helping design, implement, and monitor serves as an example of cultivating a champion for the convergent PHC/HIV agenda (with respect to PMTCT).
- Private sector involvement—Social corporate responsibility in action and its potential to influence the PHC and HIV response, with respect to industries who play a critical role in Angola, is not clearly mapped out.
- The new UN Sustainable Development Cooperation Framework (UNSDCF 2024-2028) includes a more prominent focus on PHC.

#### **4.2.1. What has been achieved since 2020 in terms of applying a PHC approach to HIV responses?**

The achievements described below briefly highlight efforts of the various Joint Team members in advancing HIV integration and interlinkages with PHC. This is not and all-inclusive list of achievements yet illustrative of the concerted efforts undertaken; additional highlights are found in later sections of the report. In line with findings under section 4.1 and taking into consideration the numerous activities and achievements of the Joint Programme, there is need to aggregate all the various efforts into a holistic approach that feeds into a single national system with a broad-based approach to policy and action so that people and communities are adequately empowered.

**Under the auspices of UNICEF, the Joint Programme has helped strengthen the integration of SRHR and HIV services through reviewing, providing oversight, and monitoring of integrated strategies and plans in addition to supporting PMTCT and early infant diagnosis within ANC settings.** These efforts have resulted in the provision of technical assistance and financial support for the expansion of adolescent youth friendly services including training health providers to provide sexual, reproductive, maternal, and mental health, HIV, gender-based violence, and nutrition services to adolescents in Luanda-Sul, Bie and Huambo provinces albeit in a small number of municipalities. This work is completed by the activities of UNFPA in responding to the needs of adolescent girls and young women and their SRHR, menstrual health and HIV/STI prevention needs. UNICEF has also provided critical support in the development of and training on Dolutegravir (DTG) paediatrics and HIV treatment guidelines and in the identification of bottlenecks to provision of EID and integrated ANC and PMTCT as subsequent implementation of corrective actions.

UNICEF, together with UNDP, has undertaken several efforts aimed at improving PMTC including its integration into ANC which among other things has included capacity building for building community level provision of PMTCT. Together with UNDP, UNFPA and WHO, with the political leadership and advocacy of UNAIDS, the agencies have engaged with the First Lady to bring the Africa designed “free to shine” PMTCT initiative (renamed “born free to shine” in Angola)<sup>50</sup> to Angola where she became a “champion” for PMTCT integrated into ANC services. The Joint Programme has supported the initiative, seen as successful in increasing PMTCT results albeit not implemented equally across provinces, in the design, development and implementation phases. This includes supporting supervision and capacity building for community level provision of PMTCT channelled through INLS as the implementing arm. Additionally, the Joint Programme has assisted in organising conferences, dissemination and messaging activities around the initiative. However, informants expressed that there was a missed opportunity around ensuring continuity and institutionalisation of the roll out due in part to the lack of engagement and coordination with the provincial first ladies—a tenant of the regional model—which reportedly affected the “political will” at the provincial and municipal level.

Focused efforts in three provinces to link the health system and community-based health workers have been undertaken including mobile outreach services to provide a comprehensive package of service to mothers and improved access to EID. This is done by ensuring quality improvement of integrated management of ANC, PMTC, EID services through provision of training and supervision from the district level to the health centres.

UNICEF has also supported efforts to improve the quality of the data, which is considered to be poor at present, reported in the DHIS. In addition to conducting the costing exercises for the national strategic plans for HIV/viral hepatitis and STIs.

In line with component three of the PHC agenda UNICEF has provided by technical assistance and financial support to the MoH for the development of the National Community Health Policy (presently in draft format). The policy has a general objective to establish a robust and sustainable

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<sup>50</sup> The “born free to shine” initiative in Angola (as well as across the African continent where it was launched in 2018) targets the most marginalized pregnant women and their children with a comprehensive package of services to reduce mother to child transmission of HIV/AIDS.

community health structure that contributes to universal access to health care. Finally, there is also a collaborative effort between UNICEF, UNDP and WHO to develop a technical product on the socio-economic determinants of health to strengthen PHC.

**Lessons learned during implementation include the need to:**

- continue, and increase, data improvement activities for the collection, registration, and analysis of data
- intensify integration of HIV in PHC including expanding the testing and diagnosis of children on nutrition, paediatrics, and immunization services
- reinforce supportive supervision to the health facilities implementing the transition
- continue training of health professionals on HIV guidelines
- advocacy focusing on the municipal level pays off as witnessed by two municipalities adopted the “Todos Unidos pela Primeira Infancia” (TUPPI) programme which includes care for pregnant adolescents amongst other activities.

**WHO serves a critical role in developing and disseminating normative guidance and subsequent training of health care providers as well as exerting its convening power around critical issues including HIV interlinkages and integration in PHC.** The work of WHO focuses on technical support to strengthening programme management, capacity building support and support to monitoring and evaluation and surveillance efforts. WHO have led the elaboration of forms for the new treatment policy (DTG) and supported related training, roll out and meriting efforts. WHO has provided guidance and capacity building to health professionals and CSOs on HIV prevention and treatment guidelines, integration of SRHR and HIV services, TB prevention among PLHIV among other topics. WHO have also provided technical and financial support to INLS and the MoH to train health care workers and data managers on the use of tools that feed into the DHIS2 in an attempt to improve the transition from paper-based to electronic transmission and to improve data transmission from health facilities to the INLS in an effort to promote the use of an integrated data management system.

WHO is currently planning for the upcoming health facility assessment where certain HIV aspects will be highlighted including promotion of integration of prevention protocols in Sexual, Reproductive, Maternal, Newborn, Infant and Adolescent Health (SRMNIA) programmes, strengthening the information systems at the level of the health units and integration of prevention activities with events held by other programmes and mass events.

**Lessons learned during implementation include the need to:**

- engage more in joint planning and monitoring to improve implementation within the Joint Programme
- improve coordination between various agencies and INLS.

**Promotion of prevention among KPs through engagement of communities and civil society, along with an emphasis on SRHR and HIV integration through comprehensive sexual education comprise the majority of UNFPA activities as part of the Joint Programme efforts.** UNFPA has a multisectoral focus to HIV prevention and service provision working with the Ministry of Education, Ministry of Interior, INLS, MoH and others in line with a the PHC multisectoral policy and action component which focuses on addressing the broader determinants of health.

Working with the Ministry of Interior, UNFPA assisted with the development of a national framework for prevention in prisons in addition to testing and counselling services employing peer educators for prevention messaging. Efforts have also included training health care workers on SRHR and HIV integration at decentralized levels as well as equipping civil society members with skills to provide information services for HIV and gender-based violence prevention, reducing maternal mortality and addressing harmful cultural norms and practices to name a few intervention areas. Together with the Ministry of Education, UNFPA continue to train teachers and peer educators on comprehensive sexuality education that includes HIV along with other diseases and services. UNFPA has also led the conduct of a condom situation analysis and will serve a critical role in assisting the INLS to conduct KP



size estimates (female sex workers in Luanda)—advanced planning already realised—and continued support to the development of tailored prevention messaging and training for KPs.

In addition, UNFPA, working with UNDP as the Principal Recipient through funding from Global Fund are targeting adolescent girls and young women with a package of services delivered by “activistas”, adolescent girls and young women in schools, community neighbourhoods and health facilities. Critical to this package is the development of “tailored SBCC activities ... including social media; addressing risk factors in Angola that specifically focus on early sexual debut and unwanted pregnancy...”<sup>51</sup> which are critical areas given the high unwanted pregnancy rates and early sexual debut in the country.

**Lessons learned during implementation include the need to:**

- capitalize on South-South regional cooperation interventions which were well accepted by the Ministry of Interior authorities and raised awareness around what informants consider “sensible issue” in Angola (e.g., condom distribution in prisons, stigma reduction)
- continue working together with UNAIDS and UNODC to improve the joint programming approach and expand the opportunities to put HIV prevention in prisons into the national agenda priorities.
- capitalize and expand the UBRAF funding in Angola which has allowed UNFPA to increase the integration of SRHR services package for adolescents and youth, with focus on HIV as well as early pregnancy prevention.

**Key achievements of UNDP contributing to HIV and PHC integration include engaging communities and KP groups to combat stigma and discrimination, treatment adherence efforts and technical and financial support to INLS for the conduct of the stigma and discrimination Index 2.0 survey.**

At the Municipality and community level UNDP has focused efforts on provision of technical assistance to support treatment adherence and PMTCT grounded in a rights-based approach in part through provision of funding to the organizations, training of health care providers and CSOs and engagement of municipality leadership in rights-based approaches. They have also used mobile solutions to improve adherence and access to care for vulnerable populations through establishment of a patient follow-up system including virtual check-in with patients.

UNDP also works with civil society through organizational development support to the National Network for AIDS service organization (ANASO) and its member organizations in addition to supporting policy development and increasing awareness of KPs to SRHR services. Small grants have been provided to IRIS<sup>52</sup> and AIA<sup>53</sup> to support KP and LGBTQI-led activities to combat stigma and discrimination. The grants have helped IRIS to development a four-year strategy, train staff on S&D and provide services to targeted KPs. AIA have provided psychosocial support services to KPs, along with safe spaces and dissemination of SRHR and HIV prevention messages.

To combat stigma and discrimination, UNDP addresses the legal environment through support to implementation of the Action Plan related to the HIV Legal Environment Assessment. UNDP have also supported development of a multisectoral roadmap for SRHR of the young KP and are starting the development of a KP Strategy, inclusive of young KP issues. This will be followed by a workshop for judges and prosecutors on non-discrimination and inclusion of young KPs with a focus on negative practices/harm of HIV criminalization and the rights of LGBTQI+ people in Angola through

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<sup>51</sup> Funding Request Form Angola 2020-2022 [unpublished]. The Global Fund; n.d. Pages 37 and 38.

<sup>52</sup> Iris is a KP organization targeting SRHR services, HIV prevention messaging and testing along with referral for treatment and support of retention in care for men who have sex with men and gay men and transgender people, with a focus on young MSM and TG.

<sup>53</sup> AIA ([Arquivo de Identidade Angolano](#)) is a KP organization targeting LGBTQI+ focusing on activism and justice for women. Some of the services offered by AIA include legal advice, professional counselling, HIV and SRHR prevention messaging and a safe space (shelter) for those in need.

budgetary synergies with #WeBelongAfrica Inclusive Governance Initiative<sup>54</sup> (see section 4.4.2). UNDP has also supported the conceptualisation and implementation of an HIV and Social Protection Assessment, the Stigma and Discrimination Index 2.0 Survey and the review of the national strategic plan (HIV, Hepatitis and STIs). UNDP has played a role in the development of PEN VII along with supporting advocacy efforts for an increase in domestic financial resources.

**Lessons learned during implementation include the need to:**

- support synergies for a more integrated approach on SRHR and HIV response to young KP and LGBTQI people by supporting DNSP, INLS and KP and LGBTI-led CSOs
- provide support to multi and intersectoral responses against stigma and discrimination suffered by KP and LGBTQI people in coordination with the Joint Team
- provide KP and LGBTI-CSOs with support for organizational capacity building and resource mobilization.

**UNAIDS has played a critical role in supporting the generation and analysis of data and its use to better inform the national strategic plan and its subsequent programme implementation, coordination of efforts across the spectrum of the HIV response, and in its work on empowering civil society to respond to the HIV needs of communities and KPs.** UNAIDS provides critical support in the production of spectrum data in addition to routine technical assistance aimed at generating evidence, analysis and utilisation of data. The assistance also focuses on improving data quality including supporting the INLS to establish a framework for data organization and quality checks. As noted by informants, the spectrum estimates can be used beyond HIV planning for family planning and ANC as they generate estimates on young girls most at risk of getting HIV. The data can also be used in other sectors (e.g., education sector) working with young girls as it allows for the identification of geographic location and spots that are high priority for interventions.

UNAIDS is applauded for its role in bringing CSOs to the forefront in the HIV response. This includes strengthening the capacity of civil society to increase uptake of testing and adherence on ART with a focus on KPs.

Additionally, UNAIDS is recognized for its efforts to strengthen coordination and partnerships, through their convening power, despite its decline during COVID-19 (see Section 4.1.2). Through its continued networking activities, UNAIDS has fostered both discussions around the integration of HIV into PHC and established closer partnerships with PEPFAR and Global Fund (see Section 4.1.3). They have also served a critical role in the development of the Joint Plan and the UNSDCF where PHC and HIV are highlighted.

**4.2.2. What is the Joint Programme doing to build political commitment for sustainable HIV financing in the context of PHC?**

**The capacity of the Joint Programme to engage its leadership, advocacy and policy dialogue expertise to influence donor and government commitment and financing for HIV has been acknowledged by government and future support identified.** WHO, UNICEF and UNAIDS were instrumental in assisting the government to convene a multisectoral discussion around PHC which led to the development of the PHC financing action plan (see Section 4.1.3). The plan highlights the need to increase domestic funding sources through tax legislation reformulation (World Bank to support) and engaging in advocacy meetings with provincial government to review inefficiencies in health funding allocation (UNICEF financial support and WHO, UNICEF and WB technical support indicated). The plan also identifies the need to strengthen the public financial management system including through the conduct of budgetary analysis (UNICEF financial support and WHO, UNICEF and WB technical supported indicated), conduct a costing exercise of defined PHC packages (WHO, UNICEF and World bank support indicated) and a study on health expenditure to identify

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<sup>54</sup> We Belong Africa - The Southern Africa Young Key Populations Inclusion Initiative. The initiative seeks to boost the accountability and responsiveness of state institutions in Southern African Development Community (SADC) countries to the perspectives, rights and needs of young key populations on sexual and reproductive health and rights.

opportunities to improve quality (WHO financial support and World Bank, WHO and UNICEF technical support indicated). Although the plan (developed in June 2023) has yet to be fully endorsed the actions highlighted indicate political commitment to addressing financing for PHC and an opportunity for the Joint Programme to ensure that sustainable HIV financing is considered within that context.

UNICEF has traditionally played a critical role in conducting budget reviews and assisting with programme-based budgeting, which will move to resource-based budgeting in the near future. UNICEF has established a good relationship with the Ministry of Financing and the dream, according to key informants, is to “see UNICEF and the Ministry of Finance develop a robust budget monitoring tool” which is in line with the NDP 2023-2027 which calls for prioritising of the expansion of the Municipal Planning and Budgeting Tool (FPOM).<sup>55</sup> UNICEF has works closely with the government analysing the national development plan and budget which provides an opportunity to look further at PHC and HIV financing. In addition, UNAIDS has led the global AIDS monitoring reporting on financing of the national response and provided support to the improved costing of the national strategic plan for HIV.

Taking into consideration “municipalisation”<sup>56</sup> there is a need to focus on the financing gaps, according to key informants, at the Municipality level while at the same time recognizing that political commitment should start with Ministry of Finance. Informants also expressed concern around ensuring a holistic approach as now “each donor comes with their own agenda” when a clear determination of the necessary financing from the bottom-up level of needs which links to programme budgets which links to results is necessary.

#### **4.2.3. What are the main enablers and barriers to integrating HIV into PHC in various contexts? How is the Joint Programme addressing these at country level?**

##### **Some of the identified barriers to integrating HIV into PHC include:**

**Guiding strategy and operational plan- Lack of a clear PHC strategy and business plan is seen as a barrier however the political will to engage in discussion is seen as a potential enabler.** See Section 4.1.3 for details.

**Human resources - Capacity exists at the central level to help ensure integration of HIV into a PHC response and vice versa, noted by the many policies and guidelines that speak to different forms of primary care integration and to a lesser degree community-based integration. However, lack of capacity (in terms of education and sheer numbers) to ensure integration and assume a holistic PHC response that demonstrates impact at the municipality level is compromised.**

The World Bank, although not receiving funding from UBRAF interacts closely with the Joint Programme, is engaging in a human resource for health for UHC training (\$200million project) designed to train staff from municipality level upward in health systems management with an emphasis on accountability and data. This project targets 30,000 health care workers and includes continuous health education for all health care workers. Additionally, WB through a loan to government has planned and developed a national post graduate training system designed to increase the number of doctors/nurses with post graduate training and specialisation are produced. The planned curricula will include HIV and PHC with a focus on community aspects, planning, budgeting, and health information systems including the use of data. Kick-off is anticipated in

<sup>55</sup> Preliminary document for discussion with economic partners – United Nations; National Development Plan, 2023-2027, p. 140

<sup>56</sup> ... the policy of municipalization of health services to strengthen the system at local level, ensuring the capacity to solve the population's main problems, with the active participation of communities and other sectors with influence on the social and environmental determinants of health. Preliminary document for discussion with economic partners – United Nations; National Development Plan, 2023-2027, p. 116

2023/2024. As previously highlight (see Section 4.2.1) the different agencies have been involved in capacity building activities focusing on integration of HIV services into primary care services.

**Community response—Investment toward a coordinated and strong community response, a basic pillar of a successful PHC response has been lacking, however a draft community-based health care response strategy is currently being circulated.** Although community health agents (“activists”) exist they are funded by non-governmental entities—namely through PEPFAR and Global Fund often through international non-governmental organizations. That said with reduced overseas development assistance (Angola is a middle-income status) and the exodus of many private sector companies, the presence and activities of the international non-governmental organization sector has reduced. This in turn has affected opportunities for community health agents both in terms of continued capacity building but also in terms of sheer numbers exacerbating the already existing access issues, particularly those afflicting the most vulnerable. The draft community health strategy, which was developed with the technical and financial support of UNDP and WHO, recognizes the need for integration of health across sectors given the “multidimensional nature of community health that depends on socioeconomic and health determinants, integration, geographic convergence and coordination will be fundamental”.<sup>57</sup> The strategy presents an opportunity to engage the community level meaningfully in a holistic response to PHC including integration of HIV activities.

In line with “municipalisation” (see 4.2.2) a subnational approach to engage with governors, provincial health offices, etc., may help push forward community involvement and strengthen PHC from bottom up. UNDP as the Principal Recipient is currently engaging in a subnational approach as is WHO through sub-national offices along with support to programming at the provincial level through UNFAP and UNICEF. Together they recognise the challenges with implementation in a country that is highly centralized but also the opportunities to generate lessons learned that can be replicated elsewhere by looking at the decentralised level.

**Social services—Access to “basic” social services is a major stumbling block to ensuring a whole of society approach to PHC.** For example, Angola has some of the lowest performance with respect to both health and education statistics in Southern Africa<sup>58</sup>. Additionally budgetary commitments are equally low in comparison to neighbouring countries with execution rates not exceeding 60%. Without commitment to social sector responses on a substantial level the responses cannot be looked at on the level necessary to incite change. The commitment and actions of the UN organizations, including under the UNDSCR, with identified cross cutting issues and interventions areas targeting the social sector with interlinkages to health (e.g., social protection, food security and nutrition, health, and water and sanitation) are trying to address the social determinants of health to accelerate integration of HIV and strengthening of PHC (see section 4.1.1)

**Data quality—There is general apprehensiveness regarding the lack of quality and availability of data which is considered a significant threat to planning for integration of services.** Quality data is critical in order to plan for and improve alignment and efficiency. Concerted efforts have been taking place for decades to enhance data quality across all service delivery areas and improve comprehensive patient-level tracking. There was a significant investment in 2015-2017 in updating the monitoring and evaluation registers, DHIS2 and training, yet data quality remains one of the top areas of concern with respect to the health care system in Angola. It is reported that resources for data improvement exist at the central level and include support from the Joint Programme, however, a lack of attention and resources toward the lower level, where data originates, is evident. There have been initiatives to engage in joint monitoring/ supervision missions at the provincial and municipality level between SRHR, ANC, TB and HIV to look at data quality at the lower levels, however as HIV “has the money” other programmes are unable to join. According to informants, discussions need to be had at central level between INLS and the MoH to foster political will for joint

<sup>57</sup> Relatório Inicial / Relatório inicial, Elaboração do Plano Estratégico da Saúde Comunitária, DNSP 2023, Seção 3.3 Proposta Técnica de Resolução da Política de Saúde Comunitária\_Junho 2023

<sup>58</sup> United national Common Country Analysis, Angola, 2022.

efforts at improving data quality and this needs to be reflected within the budgets and transmitted to the decentralized levels.

**Stigma and discrimination and lack of an enabling environment to mitigate its impact—In line with the results of the stigma index and information from informants it is acknowledged that the less than favourable enabling environment for KPs plays a role in the use of primary care and HIV related health services.** This is further exacerbated by the marginalisation of CSO voices to advocate for access to comprehensive services for KPs. There is an opportunity for the Joint Programme to leverage their gravitas as a united voice to continue to advocate for human rights and gender policy and legal reform and help ensure their implementation.

**Joint Team coordination—According to informants both a lack of coordination and siloed working style of the Joint Programme coupled with a perceived focus of meeting individual agency/organizational targets (beyond the Joint Programme) are potentially jeopardising HIV integration and PHC strengthening opportunities.** Additionally, a lack of awareness among the Joint Team of the multisectoral activities, initiatives and stakeholder and ministerial connects of the Joint Team and the wider UN community jeopardizes the ability to capitalize on multisectoral policies and actions that address the broader determinants of health. It also inhibits the ability of UNAIDS to showcase with the MoH, INLS and other partners the wider UN lessons learned and good practices that address a whole of society approach to PHC including integration and interlinkages of HIV in that effort.

**Ministerial coordination—Weak coordination capacity of the MoH both internally and externally with other ministries and key stakeholders including private sector is hampering not only integration efforts but the health care response in general.** As an example, lack of coordination from central to provincial and municipality level have hampered efforts at integrating HIV and TB activities. The integration of TB/HIV is a targeted effort by UNDP under the Global Fund grants through a one-stop-shop service model however gaps in TB service provision along with quality issues, despite the Ministerial decree in 2018 defining the path for integration of HIV and TB service delivery, have resulted in less-than-optimal results for key TB-HIV indicators.<sup>59</sup> The concept has some success at TB reference hospital level but reportedly not at the municipality sites in part due to “lack of resources, poor/no supervision, and lack of leadership” and although a mandate exists at central level it is not happening at the Municipality level. The Joint Programme provided technical assistance for the one-stop-shop central level and to some provincial levels however the continuation and supervision did not continue in part due to poor coordination.

From a broader perspective, the lack of participation by government in the Health Partners meetings (see Section 4.1.3) coupled with the seemingly lack of commitment to convene the Inter-Agency Coordination Committee (see Section 4.1.3) creates a gap in the understanding of overall service provision for HIV and PHC. Given the three key components of addressing PHC, engaging in multisectoral governance platforms is critical to ensuring the whole of society approach.

The coordination and linkages between departments, including an understanding of the activities and how they can be integrated, is not optimal according to informants who cited challenges with lining HIV activities (under the INLS) with SRHR activities which are under the public health department.

### Some of the identified enables/potential enablers to integrating HIV into PHC include:

**Champions for the response—The First Lady’s initiative, which the Joint Programme assisted in helping design, implement, and monitor serves as an example of cultivating a champion for the convergent PHC/HIV agenda (with respect to PMTCT).** This cultivation, in this case generating high level of visibility down to the Municipality level, is thought to have contributed to the improvement

<sup>59</sup> Global Fund HIV, TB, Malaria and RSSH Fund Request Application, Allocation Period 2020-2022. November 2019

of PMTCT results and could serve as an example for future efforts on a larger scale. The First Lady has requested UNAIDS and the Joint Programme to assist in the design of the next phase to include a focus on young girls with the recognition of engaging in a multisectoral response with particular attention to the social protection factors that need to be addressed. This is an opportunity to further, and bring more visibility, to the integration agenda.

**Private sector involvement—Social corporate responsibility in action and its potential to influence the PHC and HIV response, with respect to industries who play a critical role in Angola, is not clearly mapped out.** The private sector should play a role in achievement of the SDGs however their commitment to engaging in improving the health care systems needs strengthening. Informants expressed that coordination between the private sector and the public sector is required to meet both individual and public health needs, this goes beyond private sector health care providers to those working in other sectors. For example, mapping of the current situation/services/results and joint discussions between the Ministry of Mining and Petrol and the MoH presents an opportunity to further private sector involvement and contribute to the multisectoral approach to PHC in Angola. This presents an opportunity for the Joint Programme to facilitate such discussions.

Five areas of potential impact on institutional arrangement and implementation of the SDGs were identified in the Common Country Analysis<sup>60</sup>. One of the areas includes “the involvement and partnership alliance with the private sector” which both attracts and steers domestic investment and could support the Government in achieving the SDGs. It was noted that “it is possible to streamline these efforts in the various line ministries and the MoH can take its share of the cake in advancing and promoting PHC service delivery.”<sup>61</sup>

It is worth noting that recent efforts are in place by the UN Resident Coordinator’s Office to revive the platform under the partnerships with the private sector for the achievement of the SDGs. The UN Resident Coordinator’s Office is taking the lead in facilitating, coordinating, and demonstrating how public-private collaboration can effectively translate the SDGs into action on the ground and thereby guide and accelerate innovation, impact, maximize investments and optimize the use of resources in support of realization of the Angola Vision 2030.<sup>62</sup>

**The new UN Sustainable Development Cooperation Framework (UNSDCF 2024-2028) includes a more prominent focus on PHC** based on “conscious decision and a promise as a CT to work more in PHC and integrate the different aspects of health care in all the work they do”.<sup>63</sup> This also includes addressing social protection and attention to human rights, gender, and youth. Addressing inequalities and leaving no one behind is one of the cross-cutting principles of the new cooperation framework. According to informants, this commitment to the government presents an opportunity to further HIV integration into PHC and strengthen the PHC agenda and for the UN team (including the Joint Programme) to strengthen its engagement with government on a whole of society approach, which has not manifested itself as a particular strength to date.

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<sup>60</sup> United Nations Common Country Analysis, 2002, Page 79

<sup>61</sup> United Nations Common Country Analysis 2022, Page 79

<sup>62</sup> Ibid

<sup>63</sup> Key informant interview

### 4.3. EQ3 To what extent is the Joint Programme using investments, infrastructure, innovations, and lessons learned from the HIV response, including adaptations during the COVID-19 pandemic, to improve broader health outcomes?

#### SUMMARY OF FINDINGS- EQ 3

- The Joint Programme uses HIV investments, assets, infrastructure and innovation to strengthen the wider PHC agenda.
- Legitimizing of the role of communities in health governance and in processes that allow for greater community and civil society involvement, fostered through Joint Programme activities, has gone beyond HIV activities.
- Joint Team members engaged in a number of responses to the COVID-19 pandemic tapping into HIV resources/programming that have the potential to strengthen the wider health system and a wholistic public health response given continuation and expansion of efforts.

#### ***4.3.1. To what extent is the Joint Programme leveraging HIV investments, knowledge, infrastructure, approaches, and innovative models developed by the HIV response to strengthen broader health outcomes? Are there any untapped opportunities?***

**The Joint Programme uses HIV investments, assets, infrastructure and innovation to strengthen the wider PHC agenda.** This is done in part through integration of HIV activities and efforts with other diseases and within the larger primary care system as previously highlighted in section 4.2. In addition to those examples, under the auspices of the Global Fund HIV grant, administered by UNDP, the integration agenda is being pushed forward and is contributing to broader health systems improvements tapping into health systems strengthening activities that target laboratories, the supply chain and quality of care improvement. In addition, given the challenges in reach through the public health system the Global Fund shifted activities. This shift, building on lessons learned from HIV implementation, focuses on strengthening community systems and ensuring human rights barriers to health and gender are confronted. This includes continued support to ADECOS and activists through an integrated package of HIV, malaria and TB services in addition to EPI, RMANCAH and STI services. Taking a provincial approach to grant implementation allows for an integration focus which is anticipated to improve not only HIV outcomes but broader health outcomes.

**Legitimizing of the role of communities in health governance and in processes that allow for greater community and civil society involvement, fostered through Joint Programme activities, has gone beyond HIV activities.** For example, ANASO, with both technical and financial support of the Joint Programme alongside its HIV activities has now included TB, malaria and other diseases into their scope of work to generate attention to a more holistic health care approach. The President of ANASO now serves as the Vice-Chair of the CCM for the Global Fund focusing on HIV, TB, malaria and resilient and sustainable systems integrated response which should foster improved representation of civil society in the integration agenda.

#### ***4.3.2. To what extent is the Joint Programme using and promoting wider adoption of adaptations in service delivery developed in response to COVID-19 to improve broader health outcomes?***

**Joint Team members engaged in a number of responses to the COVID-19 pandemic tapping into HIV resources/programming that have the potential to strengthen the wider health system and a wholistic public health response given continuation and expansion of efforts.**

UNDP, as the Principal Recipient for the Global Fund was able to lend the infrastructure built under the grant to the COVID-19 response not least of all laboratory services, access to the UNDP

procurement platform in addition to provision of expert procurement advice to the DNSP in the specification, quantification and sourcing of health products and equipment. These activities demonstrated how HIV assets can be tapped into in response to a public health emergency but also showed the opportunities for integration in the future. Along with other Joint Team members UNDP also negotiated Global Fund financing for the response to COVID-19.<sup>64</sup>

With support from the European Union (APROSOC), UNICEF was able to reach families and children up to five years old in Bie and Moxico Provinces through adjustments to their social cash transfer project (Valor de Criança) during the pandemic working closely with the Ministry of Social Action, Family and Women. The project has supported the inclusion of vulnerable populations and collects disaggregated data as part of its monitoring and evaluation framework. The Swedish International Development Cooperation Agency (SIDA) also supported UNICEF with the launch of two additional emergency cash transfer programmes in Luanda which among others, targeted children living with HIV. Some of the successes realised under both efforts include the efficient online engagement with partners, the boosting of digitalisation in operational and research processes, and the Integrated Social Action Centres becoming a key platform to support intersectoral training including for critical HIV responses such as PMTCT and ANC.<sup>65</sup> The UNICEF response to COVID-19, in addition to targeting HIV service provision/social protection, targeted multiple sectors including education, water, sanitation and hygiene, emergency relief and others. According to informants the experience gained from this multisectoral response to a public health threat and the need to address a whole of person perspective can be brought to bear on future responses to emergencies and PHC planning and response in general. Continuation of these programmes post-COVID brings HIV treatment even closer to ANC and paediatric care and increases women's incentives to attend pre-natal check-ups, deliver in an institutional setting and follow up on the child's needs (e.g., for ART, immunisation)

WHO, UNDP and UNAIDS, in discussion with PEPFAR, further advocated and assisted with the implementation of differentiated service delivery modalities to improve access to HIV services to mitigate the COVID-19 pandemic. These efforts included multi month dispensing (MMD), differentiated HIV testing services for vulnerable populations and decentralized drug distribution all designed to improve identification of HIV and increase ART coverage and continuity for different demographic risks groups. Although MMD for ART was already part of the HIV protocols (however for 3-month dispensing) its implementation was not fully realized, and a prolonged period of six months was promoted during COVID-19. With social distancing and 'stay at home' messaging, a reduction in the availability of public transportation and a reduction in the number of health workers providing services it was critical to ensure consistent access to those on treatment. MMD implementation increased during the pandemic; a model that has the potential to be used for other long-term diseases tapping into the HIV experience.

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<sup>64</sup> UNDP Angola Support to the National Response to Contain the Impact of COVID-19, Situational Analysis. <https://www.undp.org/sites/g/files/zskgke326/files/migration/africa/undp-rba-covid-angola-apr2020.pdf>

<sup>65</sup> UNICEF Angola COVID-19 Situation Report, No. 6, September 2020. <https://www.unicef.org/media/83406/file/Angola-COVID-19-SitRep-September-2020.pdf>



#### 4.4. EQ4: To what extent does the Joint Programme ensure that equity, gender, and human rights issues, including the needs of KPs, are sufficiently addressed when leveraging HIV and PHC interlinkages and integration?

##### SUMMARY OF FINDINGS – EQ4

- An enabling environment and policy framework for the provision of social protection exists, however the scope of health services within these is quite narrow and the specific targeting of PLHIV and other KPs is non-existent.
- The Joint Programme is using its strategic information and analytic capacity and its partnerships with PLHIV and KP networks in generating data on how stigma and discrimination affects those most affected by HIV and identifying and assessing potential benefits and risks in programming activities to combatting S&D.
- Engaging civil society in the HIV response, positioning them at the forefront of decision-making and service delivery (medical and non-medical), has been the focus of the Joint Programme in part to help address stigma and discrimination and contribute to an enabling environment for equitable access to integrated HIV services.
- The Joint Programme is supporting the integration of HIV into systems for health and other sectors in various ways including the formulation of necessary strategic documents, improving data collection, management, and use, as well as promoting and strengthening community-based approaches to integration.

##### 4.4.1. Which locations and population groups are potentially benefiting or being left behind?

**An enabling environment and policy framework for the provision of social protection exists, however the scope of health services within these is quite narrow and the specific targeting of PLHIV and other KPs is non-existent.** Despite the proliferation of safety net programmes, the activities/programmes are reportedly “small, scattered and highly fragmented” with low coverage.<sup>66</sup>

The Joint Programme has been supporting the government to update, implement and monitor the application of laws related to equity, gender and human rights working with different government and non-governmental entities responsible for these areas. However, the most recent law on HIV (Law No. 8/04 from 2004<sup>67</sup>) has some key challenges including, some of which have been addresses, others have not:

- no special protection for KPs, including young KPs
- insufficient provision for vulnerable populations
- prohibition of HIV testing for minors without consent of parents or designated person or authority proscribed by law
- lack of a specific competent authority to respond to complaints *e.g.*, regarding discrimination, violence and access to health services
- need for provisions guaranteeing the right of association for key and vulnerable populations.
- lack of express reference to the right to sexual and reproductive health.

Informants expressed that activities to integrate key groups with religious communities and civil society have been carried out and include meetings with the LGBTQ+ community and churches,

<sup>66</sup> HIV sensitive social protection in East and Southern Africa, fast track countries, November 2021, p.12

<sup>67</sup> Angola - Legal Environment Assessment for HIV and the Right to Sexual and Reproductive Health. UNDP; 2021 ([Legal Assessment](#), accessed 3 July 2023).

marches to reduce stigma and promote prevention, lectures, distribution of key messages, and training of health technicians to create KP-friendly services.

The most comprehensive programming for HIV, including a focus on KPs, is under the Global Fund grant, however this covers only Benguela and Cuanza Sul under current UNDP activities as the Principal Recipient. Most of the provinces in Eastern Angola seem to be “left behind”. Even the LGBTQI community itself faces difficulty reaching out to its constituents to assess the state of affairs due in part to location and lack of funding targeting those areas. Of note however is the reach of the other cosponsor activities which go beyond Benguela and Cuanza Azul and includes provinces in Eastern Angola.

#### **4.4.2. How is the Joint Programme supporting countries to ensure stigma and discrimination free services for PLHIV and vulnerable and KPs in all service delivery settings, including primary care?**

**The Joint Programme is using its strategic information and analytic capacity and its partnerships with PLHIV and KP networks in generating data on how stigma and discrimination affects those most affected by HIV and identifying and assessing potential benefits and risks in programming activities to combatting S&D.** Together UNAIDS and UNDP played critical roles in conducting the stigma index and in the dissemination of the findings along with incorporating them into programming, reflected namely in the Global Fund grant and activities and the work carried out with civil society. Additionally, UNDP is providing technical, policy, and advocacy support to reduce HIV related stigma and discrimination affecting the HIV response, including through leveraging the global partnership for action to eliminate HIV-related stigma and discrimination. This has included capacity building of community organizations to address stigma and discrimination and promote HIV prevention, access to ART and retention in care in two selected provinces. Support has also included training of health care providers and CSOs in human rights-based approaches to HIV prevention and treatment along with delivery of friendly services towards PMTCT.

**Engaging civil society in the HIV response, positioning them at the forefront of decision-making and service delivery (medical and non-medical), has been the focus of the Joint Programme in part to help address stigma and discrimination and contribute to an enabling environment for equitable access to integrated HIV services.** Engaging and empowering civil society and communities, one of the components of PHC, is best demonstrated through the meaningful involvement of people living with and affected by HIV in the HIV response<sup>68</sup>. To that extent, the Joint Programme has been involved in policy development, strategic planning, service delivery and quality assurance, monitoring and evaluation and resource mobilisation working hand-in-hand with civil society, KPs and PLHIV to help address their needs.

For example, UNFPA has engaged key and affected populations, including prisoners, MSM, female sex workers, transgender populations and LGBTQI, to support their self-empowerment and their role in advocacy, service delivery and beyond through round-table discussions on HIV prevention to scale up access to HIV testing and counselling. Additionally, activities have included the conduct of awareness raising sessions, facilitating access to HIV testing and counselling in hot spots and referrals to care for those who are HIV positive. UNFPA has also focused activities on the scale up of innovation in HIV testing and case-based identification through index tracing in hot spots, with focus on sex workers, MSM, and pregnant in Luanda City.

UNAIDS has been instrumental in increasing the number of actors in the CSO realm and strengthening their capacity to advocate and respond to the needs of the KPs (see Section 4.2.1).

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<sup>68</sup> Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030, p.14 [GHSS 2022-2030](#)

#### **4.4.3. To what extent is the Joint Programme supporting countries to integrate HIV into systems for health and other sectors appropriately in different epidemic and health systems contexts?**

The Joint Programme is supporting the integration and interlinkages of HIV into systems for health and other sectors in various ways including the formulation of necessary strategic documents, improving data collection, management, and use, as well as promoting and strengthening community-based approaches to integration. These efforts are targeted beyond the health sector and include working with the Ministry of Education, Ministry of Women and Social Affairs, Ministry of Justice, etc. As an example, UNICEF has supported the roll out of the social transfer cash-based incentive to improve treatment adherence amongst the most vulnerable PLHIV (women) and pregnant women. The lesson learned from this experience could potentially be tapped into with respect to the scale up of the social protection programme funded by the World Bank, the KWENDA cash transfer programme that has the potential to curb poverty in the short term yet is currently not targeting PLHIV.<sup>6970</sup>

Through CSE, UNFPA has facilitated the training of peer educators to impart HIV and SRHR message to in and out of school youth and through HIV and AIDS clubs among young people. This has included lobbying with the Ministry of Education and supporting them with the development of the CSE curricula to ensure access to critical HIV and SRHR information for young people. In Luanda, 200 teachers are scheduled to be trained on the CSE curriculum at both the primary and secondary level. It was voiced that in addition to SRHR and HIV, gender-based violence should be included as part of the curricula.

#### **4.5. EQ5: What is the added value of the Joint Programme in terms of leveraging HIV and PHC interlinkages and to what extent is the Joint Programme sufficiently resourced to pursue this?**

##### **SUMMARY OF FINDINGS – EQ5**

- It was expressed by multiple informants that the added value of the Joint Programme is the “ability of the agencies to tap into their respective areas of expertise” and the potential to engage multiple sectors in the HIV integration into PHC agenda.
- The Joint Programme lacks the necessary resources to further HIV integration/interlinkages activities within the PHC, while simultaneously strengthening the PHC response in line with commitments to the government of Angola.

##### **4.5.1. What is the added value of the Joint Programme in terms of leveraging HIV and PHC interlinkages? (Joint Programme ways of working, collaboration, synergies, and comparative advantages)?**

It was expressed by multiple informants that the added value of the Joint Programme is the “ability of the agencies to tap into their respective areas of expertise” and the potential to engage multiple sectors in the HIV integration into PHC agenda. Based on the comparative advantage of the different Joint Team members as highlighted in the previous sections, coupled with the much-lauded leadership of UNAIDS, the Joint Programme has been reasonably successful in achieving the

<sup>69</sup> The Kwenda programme, 2020 to 2023 with a budget of USD 420 million, targets families to receive monthly payments of Kz 8,500 for a period of one year. As of August 2022, some 829,500 out of the target 1.6 million poor households had been registered, especially in the poorer provinces. Almost 590,000 of these households have received at least one quarterly cash transfer, 62% of whom with a female household representative receiving the payment. The project will continue beyond 2023 and be scaled up with government resources.

<sup>70</sup> UN Angola Common Country Analysis 2022

outcomes that were sought with UBRAF funding despite operating through challenging circumstances such as the COVID-19 pandemic. This includes outcomes related to integration of HIV activities with PHC. The level of coordination and cooperation pre-COVID19 times among the Joint Team was unanimously agreed to be commendable and already showing signs of returning to normal. That said further alignment of activities and engagement in strategic thinking and prioritization focusing on HIV integration into PHC from a holistic perspective, including tapping into expertise, ongoing activities, partners and ministerial and private sector connections outside of UBRAF activities would further efforts. According to informants the mobilization of additional resources, transparency in their use and accountability are also aspects that have been carried out by the Joint Team. Additionally, both the financial and technical support afforded to the MoH and INLS and attempts to ensure coordination between the NDSP and INLS are appreciated by government.

#### **4.5.2. To what extent does the Joint Programme have the necessary skills and resources to contribute to strengthening HIV and PHC integration and linkages?**

**The Joint Programme lacks the necessary resources to further HIV integration/interlinkages activities within the PHC, while simultaneously strengthening the PHC response in line with commitments to the Government of Angola.** Informants expressed that the Joint Programme is exactly what is needed within the UN organizations, including the model of how the agencies work together, in order to both push forward the HIV integration/interlinkages within a PHC agenda and comply with the commitments of the UNSDCF. It is well placed as it draws from the abundance of skills and resources acquired from its globally oriented experience and regional networks and initiatives, so that its contribution to strengthening HIV and PHC integration and linkages is locally tailored and effective.

That said, agencies need to provide the resources to ensure that country offices can deliver, at present staffing within the agencies is considered inadequate which can result in the Joint Programme being “left discredited” according to informants. Based on staffing patterns reported in the JPMS, UNAIDS and UNDP are the only organizations with full time positions funded through UBRAF. It should be recognized that funding of posts may be facilitated from headquarters or at the regional level however the below is based on UBRAF funding only. Most notably, WHO receives only 5% funding for one position (Program Assistant) and 10% for another (HIV officer), through UBRAF funding. This is despite their critical role of setting normative guidance, training of technicians, monitoring the health situation, and advocating with government, key stakeholders, private sector and others for a stronger PHC and UHC response that addresses integration of not only HIV but consideration of other NCDs, social protection services, mental health services, nutrition and other critical areas.

**Table 2: UBRAF funded staffing<sup>71</sup>**

Agency	Positions – JPMS 2023	Equivalent of full-time positions – JPMS 2023	Positions – capacity assessment	Equivalent of full-time positions capacity assessment
WHO	2	.15	1	.70
UNICEF	3	.70	2	.60
UNFPA	3	1.60	3	1.60
UNDP	5	2.15	4	4.00
World Bank	0	0	1	.70
UNHCR	1	.75	1	.10
UNAIDS	3	3	4	4.0
<b>Total Positions</b>	<b>17</b>	<b>8.35</b>	<b>16</b>	<b>11.70</b>

<sup>71</sup> Based on 02 June 2023 extract from the JPMS

Discrepancies exist between what was reported in the 2022 Capacity Assessment (although data was from 2020)<sup>72</sup> and data from the JPMS. The difference could reflect the mobility of staff resulting in vacancies or the inability to recruit new staff among some Cosponsors. The difference may also be attributed to “a 30% reduction in funding last year (2022)” according to informants. Based on the 2022 capacity assessment Angola is classified as a “country with the largest or large gap” yet there was an equivalent of 11.7 full time positions in 2020 compared to 2023 with the equivalent of 8.35 full time positions. One can assume that Angola would continue to be classified as a “country with the largest or large gap”.

## 5. Conclusions and considerations going forward

### 5.1. Summary of conclusions

Opportunities exist within Angola to further advance HIV integration and interlinkages while at the same time strengthening PHC. The integration of HIV into a PHC approach, and vice versa, which focuses on people-centred services has the potential to not only benefit HIV outcomes but broader health outcomes. That said the benefits versus risks versus trade-offs of the integration, including for KPs and other vulnerable populations and specific systems for health need to be considered. The Joint Programme has produced numerous publications including guidelines, policies and strategies to support integration of services such as HIV and SRHR, PMTCT, TB, paediatric treatment and care, etc. which are being employed in Angola in addition to co-location of a services within primary care settings which can be built off. The following presents a summary of conclusions from the evaluation.

- **Opportunities for integration are vast but require systems strengthening and structural change within the MoH and INLS with linkages to social protection, private sector, education, environment, and others in addition to a competent and adequate cadre of human resources.** The interest and initiative by key stakeholders (Gavi, PEPFAR, Global Fund, Joint Programme) to assist the government to establish the Luanda Declaration on PHC and immunisation should be capitalized on and tapped into what could be considered win-win scenarios recognising that given the relative weakness of the PHC system at present, these win-win scenarios may only materialise in the longer run. There is also an opportunity further strengthen human resources for health capacity through ongoing and upcoming World Bank grants.
- **The Joint Programme has been a champion of engaging the government (INLS and DNSP) in dialogue around key aspects HIV integration within a PHC approach (critical elements of PHC are already engaged in under the HIV response—community systems, leadership, governance, etc.), yet further work on policy development and framework design is urgently needed to maintain already demonstrated political will.** Further efforts are needed to strengthen the interlinkages of HIV with PHC through a holistic approach to policy dialogue, building off the Luanda Declaration. Critical to this is the recognition and inclusion of all stakeholders including KPs, CSOs and community representatives, health care providers, researchers, funders, private-sector, other government ministries and critical decision makers. The Joint Programme is in a position to continue to guide the government on the PHC agenda and transform political commitment into action ensuring a focus on social equity and health as a human right (cornerstones of PHC) while at the same time leveraging existing HIV integration efficiencies and synergies.
- **The Joint Programme, in particular UNAIDS, WHO and World Bank, with their leadership, advocacy, and technical gravitas coupled with their convening power are in a position to further guide the government and stakeholders engaged in PHC and HIV to push forward commitments laid out in the Luanda Declaration to strengthen both PHC and address HIV in a synergistic**

<sup>72</sup> Annex 7: Human resources data table, 2020 – UNAIDS Joint Programme Capacity Assessment, Final Report, Version 28 April 2022, page 131

**manner.** Although steps have been made to establish an agenda for PHC through the signing of the Luanda Declaration and development of a draft PHC financing plan, coordination of efforts and clear pathways for next steps have not been defined. Joint Team agencies have been identified for provision of technical assistance under the PHC financing action plan and therefore in a position to help ensure that HIV financing is looked at in the context of PHC financing and the wider context of UHC financing (a key area for World Bank as part of its health systems strengthening focus), building on existing costing exercises, ensuring that HIV is part of a basic benefit package.

In addition to experience and expertise in filling the gaps in existing governance systems and development of financing and policy guidelines and frameworks, the Joint Team is well placed to improve upon strategic information systems for PHC so that integration can be optimised.

- **The existing Inter-Agency Coordination Committee, although seemingly dormant, has the potential to serve as a coordination body for the PHC agenda in Angola.** This committee, with the commitment of the Joint Team, could help fill the coordination gap on the side of government and with the support of technical partners, could serve as a vehicle for fostering further political will and commitment of both the PHC and HIV integration agendas. The committee, led by the MoH would be well placed to carry out a mapping of existing services, their location and implementers including from the private sector.
- **Government looks to the Joint Team, particularly the UNAIDS Secretariat, to help mobilize and foster integration and interlinkages among the INLS and various programmes under the DNSP.** To that extent more focused efforts on dissemination of good practices and advocacy support is needed from the Joint Programme to showcase existing interlinkages which highlight the benefits of integrated response aimed at improving PHC. Tools developed and advocacy efforts can help support and foster mobilization of other sectors as well.
- **The lack of an organized community-health strategy has hampered a meaningful scaled contribution of the communities, CSOs, and KPs to both the HIV response and to achieving the third component of PHC—empowered people and communities.** The Joint Team has actively been involved in the development of the community health strategy, work for which they are applauded. Opportunities exist for the Joint Programme to assist in finalizing the strategy including designing a roadmap for the way forward including assisting with a communication plan and materials. As part of this effort the Joint Team is well placed to help ensure not only a focus on HIV integration but of other diseases and health issues (including comorbidities, SRHR, maternal and child health etc.) and health promotion, education, service delivery into existing HIV and TB community systems in the country.
- **Both HIV and PHC responses require multisectoral policy and action that looks at the broader determinants of health including social protection, legislative aspects relating to environment, workplace, education, etc.** The Joint Team, beyond their activities under the auspices of the Joint Programme, have the potential to expand on their existing experience from other sectors and large-scale programmes that focus on education, environment, regulator works, human resource and beyond to benefit existing efforts.
- **The data needs of the country are not being met despite extensive and extended efforts of the Joint Team and other stakeholders, a situation which is exacerbated at the lower levels.** Under the Global Fund grant UNDP is making strides at improving the quality of data as part of the DHIS2 based on a focused provincial approach. Additionally, UNAIDS plays a critical role in the provision of key data both for generating estimates but also for routine operational purposes. There is a role for the Joint Programme to contribute to the generation of strategic information including on equity in prevention and care and to increase efforts to look at routine data for planning purposes. This experience can be used for other services such as family planning and antenatal care programming but without addressing the quality of existing data these exercises are compromised.

## 5.2. Considerations for strengthening the Joint Programme contributions to alignment and integration

The following presents a summary of considerations moving forward diving by strategic and operational considerations.

### 5.2.1. Strategic

#### Investment case for PHC

**To fully realize the benefits of integration of HIV into PHC the Joint Programme should consider engaging in a strategic investment case exercise to enable better iteration between the ambition of integration and the feasibility of delivering that ambition.** This should take into consideration how government will benefit from engaging in integration activities and the potential risk involved, given the changes required, with due consideration of the costs, savings, available funding, and the potential return on investment. This should also include consideration to the requirements in terms of capacity, capabilities and institutional readiness. The timing of this investment case is critical, the results of which should feed into the ambitious timeline of the government for “developing a costed PHC policy and strategy by December 2023” which seems unrealistic given the current pace of advancement.<sup>73</sup>

#### Furthering leadership and political commitment

**The Joint Team should assist the government in developing a vision, which could be a product of the investment case, of how HIV assets and investments, including key lessons learned from the response which can inform PHC strengthening approaches, can contribute to achieving PHC objectives.** This should include anticipated outcomes and pathways for achievement and done with an aim to simultaneously build leadership capacity of the government response. Ideally this could be done through, or at a minimum in coordination with, the Inter-Agency Coordination Committee (see below).

**In addition, the Joint Team is in a position to help identify champions for the integration of HIV and PHC.** This effort should build on the support provided to the First Lady’s initiative and her future plans with a wider scale vision and a whole of society approach. The Joint Programme should assist the First Lady in the next phase of her “born free to shine campaign”, or design of a new initiative, focusing on a multisectoral integration agenda addressing the social determinants of health. This includes continuing and strengthening the visibility and communication around such a campaign focusing on results achieved and lessons learned. Capitalizing on the success of the existing campaign, the Joint Programme should consider actively seeking out and fostering other “champions” for the integration and PHC agendas.

#### Coordination and capacity building

**The Joint Team should assist the MoH, to reinvigorate the Inter-Agency Coordination Committee<sup>74</sup> and ensure it represents a multisectoral and multi-stakeholder advisory group inclusive of private sector, with the ability to help inform the policy dialogue.** This could include:

<sup>73</sup> These are highlighted actions, in total 23 actions are defined in the plan with clear responsible entities, timelines and identification of assistance needed from the Cosponsors

<sup>74</sup> Established on 29 June 2022 to serve as a regular cooperation mechanism for the coordination of initiatives and information sharing, aimed at strengthening primary health care

- Strengthening the capacity of the MoH, as the head of the committee, to facilitate multisectoral arrangements with other ministries and institutions, as well as within the MoH, and to engage the private sector and other actors (such as professional associations and civil society) when and where useful and appropriate including at the subnational level.
- Assisting the committee to establish a strategic framework for PHC that includes HIV integration efforts and builds off the investment case and the Luanda Declaration, and the recently developed PHC financing plan, to guide activities. This committee should explore areas of HIV integration as part of the process, beyond existing efforts.
- Engaging the committee in a provider mapping or an assessment to ensure accurate information about the scope of services engaged in by key stakeholders including the activities and their targeted groups, funding and sources, geographic locations, major partners, etc.
- Committing to communicating, disseminating and/or publishing widely the results of the committee to showcase progress toward PHC and UHC.

## Strengthening data systems

The Joint Team should facilitate discussions at the central level between INLS and DNSP to foster political will for joint efforts to improve data quality and engage in joint data systems usage including a focus on improving data quality and integrating community led monitoring of PHC and HIV. These discussions should envision a common framework for data systems and support from the Joint Programme to ensure that costing exercises are conducted and are incorporated into budgets that reflect upon activities. The Joint Programme could help reactivate the national monitoring and evaluation technical working group ensuring representation from INLS and DNSP as well as key partners engaged in and dedicated to improving data systems. Each partner could be assigned tasks on the system side to be addressed with clear accountability lines. Critically these efforts need to include looking at how to engage with and support human resources at a provincial and municipal level.

### 5.2.2. Operational

## Coordination

**Ensure that discussion around HIV and PHC interlinkages is an agenda point within the Joint Team meetings including highlighting relevant activities in other sectors.** The knowledge and information shared in meetings should be brought to the Health Partners meeting and more specifically the technical working group established to help the government develop the PHC political agenda (as part of the development of the Luanda Declaration). This working group could serve as the liaison for external coordination, communication, and advocacy activities and be part of the Inter-Agency Coordination Committee (see recommendation above).

## Internal leaderships and political commitment

**Effective immediately, the Joint Programme should engage in efforts to strengthen its role and function to pre-COVID times under the guidance and leadership of UNAIDS working together with the UN Resident Coordinator's Office.** This should include consideration of extending the focus beyond HIV through exploring the relevant ongoing and planned work of all UN and their engagement with various sectors. Together, **a UN vision of how all agencies contribute to achieving PHC objectives and how the PHC approach contributes to ending AIDS should be developed.** This vision should build on priority areas and context specific approaches based on existing and planned activities as well as technical knowledge. This effort should be led by UNAIDS, together with WHO as the lead agency on e.g., the health sector, PHC, health systems strengthening with guidance from the



UN Resident Coordinator's Office. At a minimum that vision should clearly show how the Joint Programme can further contribute to:

- generating strategic information on equity in prevention and care
- mobilizing financial resources to support an integrated response
- improving access and care for the KP to preventive and curative care
- improving monitoring and evaluation including community level systems
- increasing access to essential health services for PLHIV through development of social health protection programmes
- strengthening active and meaningful engagement of civil society in the areas of HIV-sensitive social protection and its integration within PHC.

# Annexes

## Annex 1—Key informant interview Guide

Note: the following guide is tailored to the Joint Team, we also developed tailored guides targeting the following categories of key informants:

- Global Fund, PEPFAR, BMGF, USAID, international NGOs etc.
- Government Ministry/central staff
- Facility staff/Service providers (government and or private/NGO)
- Community led/based organizations, Key population groups
- Academic/research organizations.

### **Country case studies - Key Informants Interview Guides**

#### **The UNAIDS Joint Programme contribution to strengthening HIV and Primary Health Care outcomes: interlinkages and integration**

##### **Interview guide for Joint Programme Cosponsors in country**

Introduce the consultants and key informants. Note names and positions.

Introduce the assignment: Euro Health Group has been contracted to conduct an evaluation of the UNAIDS Joint Programme’s work on leveraging the HIV and PHC interlinkages in order to strengthen these and identify opportunities for the UNAIDS Joint Programme work on PHC in the future.

The evaluation will identify how efforts to address HIV have been—conceptually and operationally—linked to the PHC approach and whether or how this can be further strengthened. The evaluation should capture the HIV-PHC interface, drawing on where things stand based on current experience and the way forward. The timeframe of the evaluation is from 2020 to date. At country level the UNAIDS Joint Programme on HIV includes the UNAIDS Secretariat Country Office and up to 11 Cosponsors. In this evaluation we are focusing on the work of WHO, UNICEF, UNFPA and the World Bank in addition to UNAIDS Country Office.

The evaluation will not only assess how the Joint Programme has supported integration of HIV into PHC and how HIV integration has improved HIV prevention, testing and treatment outcomes but also how this has strengthened PHC outcomes more broadly, e.g., improving the ability of PHC to care for people with chronic illnesses.

All information provided to the evaluation team will be kept confidential, and potential citations will not be traceable to any person or their details.

Thank you for your willingness to talk to us.

##### **List of questions**

- Can you describe any recent examples from your country where the Joint Programme has contributed to strengthen:
  - integrated service delivery (including in primary care)
  - multisectoral action and policy
  - empowerment of communities

Any notable achievements since 2020?

How is progress tracked?

#### Probing Qs

- Can you mention any recent examples of Joint Programme activities at country level to build political commitment for sustainable financing and delivery of integrated HIV services (e.g., comprehensive HIV services in health benefit packages)?
  - Any recent examples of Joint Programme multisectoral actions and policy?
  - To what extent is the Joint Programme promoting community-led approaches for demand generation and service delivery when appropriate? (and how can this potentially be improved?)
- Where does the Joint Programme *add value* through its joint ways of working on HIV and PHC integration and linkages? (e.g., convening power, collaboration, synergies etc) Probe: How is the Joint Programme using its *comparative advantage*, resources and ways of working to support HIV and PHC integration and linkages at country level? (Joint Programme leadership, advocacy, policy dialogue, convening, funding, guidance, technical support, strategic information at global, regional and country levels)
  - To what extent do you think the Joint Programme has appropriate and adequate skills and resources to leverage the HIV and PHC interlinkages? What, if any, are the main gaps, and where should the Joint Programme strengthen its capacity?)
  - What are the *main barriers* to integrating HIV into PHC and how is the Joint Programme addressing these, at country level? (Probing: are Joint Programme partners at the UHC table when discussing UHC/PHC etc?)
  - What are the *key enablers* to advance HIV and PHC integration? (Probing: How is the Joint programme tapping into these?)
  - How is the Joint Programme identifying and assessing the *main barriers and challenges to, and risks of*, HIV integration in PHC?
  - To what extent do you think that the Joint Programme has leveraged on HIV assets (investment, learnings, approaches, innovations) for broader health gains? Specific examples Any specific examples? (Probe: are there any missed opportunities?)
  - What is the Joint Programme doing to ensure *equitable access* to HIV services delivered through a PHC approach? Which locations and population groups are potentially benefiting /or being left behind?
  - Where should the Joint Programme focus its *efforts in the future* on HIV and PHC integration and linkages to maximize HIV and broader health outcomes? What should it do better or differently going forward (probing: Missed opportunities for the Joint Programme on the HIV-PHC interfaces) How can the Joint Programme best contribute to ensuring the equity, quality and sustainability of HIV services that are integrated with, or linked to, PHC?)
  - Is there an imperative to integrate HIV more in PHC? How can this support HIV outcomes? How can it support broader health outcomes?
    - To what extent are relevant plans, strategies and activities related to HIV and PHC harmonized and aligned *internally* within the Joint Programme (UNAIDS, WHO, UNICEF, UNFPA, WB) at the country level? And *externally*? (Global fund, PEPFAR etc?)
  - What can and should the Joint Programme do in the future to maximize on the interlinkages between HIV and PHC?

## Annex 2—Individuals met and group discussion participants

Individual key informant interviews			
1	Ana Ruth Luis	Director of Medical Department (also Global Fund CCM Chair)	Chevron
2	António Azevedo	Community Mobilizer	UNAIDS
3	Representative	Member	IRIS Angola
4	Rosa Camilo	Hospital Director	Kilamba Kiaxi Maternal and Child Health Hospital - Luanda
5	Adelino Gaspar	Maternal Health Director	Kilamba Kiaxi Maternal and Child Health Hospital - Luanda
6	Alume Alberto	Clinical Director	Divina Providencia Hospital
7	Mady Biaye	UNFPA Representative	UNFPA
8	Hege Wagan	Representative	UNAIDS
9	Helga Reis Freitas	National Director	MoH - National Directorate of Public Health
10	Isabel Daniel	Strategic Information Officer	UNAIDS
11	João Pires	Sr. Health Specialist	World Bank
12	Joaquina Ponttes	Supervisor, HIV/AIDS	GPSL
13	Madalena Filipe	Head of HIV	Divina Providencia Hospital
14	Maria Lucia Furtado	Director General	INLS
15	Marina Coelho	Assistant Representative	UNFPA
16	Pierre Destexhe	Health Advisor	EU
17	Representative	Member	AIA
18	Satoshi KADOWAK Ryotaro Yasuhara Adao Miguel Manuel	Chief Representative Consultant Project Formulation Programme Officer	JICA
19	Tânia Lourenço	Data Comp. Team lead	UNDP
20	Zahira Virani Fatima Santos	UN Resident Coordinator Team Leader	UN Office of Resident Coordinator
Focus group with Civil Society in Luanda Province			
1	Agostinho Jorge	Communications Officer	ANASO
2	Representative	Member	IRIS Angola
3	António Coelho	President (also Global Fund CCM Vice-Chair)	ANASO
4	Assunção Lopes	Admin Assistant	ANASO
5	Representative	Member	IRIS Angola
6	Carlos Mangureira	Secretary	Clube do Médicos
7	Representative	Member	ADM
8	Emival Marcelo	Assistant	Clube do Médicos
9	Representative	Member	ADM
10	Euclides Ribeiro	Accounts Officer	ANASO

11	Honolfo Simões	President	Clube do Médicos
12	Manuel Cruz	Logistics Officer	ANASO
13	Representative	Member	ACADEJ
14	Representative	Member	AIA
15	Representative	Member	CAJ
<b>Focus group with civil society in Benguela province</b>			
1	Adolfo E. Cambule	TB/HIV Advisor	UNDP
2	Anderson Costa	Admin Assistant	UNDP
3	Andrew Pamuchigere	Inter-Provincial Coordinator	ADPP
4	Anita Kosivola	Activist	OIC
5	Benvinda Baptista	Supervisor	OIC
6	Cristina Katchiondar	Counsellor	OIC
7	Dionísia Franco	Activist	OIC
8	Elaine Beatriz Memuana	Activist	OIC
9	Evaristo Aurélio	Counsellor	OIC
10	Felicianna Odília	Coordinator	ADPP
11	Garcia Morais Vítor	Peer Educator	OIC
12	Representative	Female sex worker	Community
13	Inácio Mário	Peer educator	OIC
14	Inácio Nangolo	Admin & Finance	OIC
15	Jerónimo Pilartes da Silva	Activist	OIC
16	Joel Rehnstrom	Director, Evaluation	UNAIDS
17	José Tchiarinola	Unknown	Unknown
18	Judite Mulongo	Counsellor	OIC
19	Kelson da Cruz	Peer educator	OIC
20	Mário Fonseca	Peer educator	
21	Sandra Tabita Calú	Counsellor	OIC
22	Tomás Borri Luciano	Peer educator	OIC
23	Victorino G. Filipe	Activist	OIC
<b>Interviews from Benguela provincial visit</b>			
1	Eugénia da Costa Paulo	Supervisor, Child Health	GPSL
2	Janeth Patrícia Helcio	Supervisor, T.B.	GPSL
3	Joaquina Pontes	Supervisor, HIV/AIDS	GPSL
4	Neusa Lazaus	HoD, Public Health	GPSL
<b>Group discussion with Cosponsors</b>			
1	António Azevedo	Community Mobilizer	UNAIDS
2	Eva Pascoal	Officer in Charge	WHO
3	Fernanda Alves	Communicable & NCDs	WHO
4	Hege Wagan	Representative	UNAIDS
5	Hirondina Cucubica	Health Officer	UNICEF
6	Isabel Daniel	Strategic Information Officer	UNAIDS

7	Marina Coelho	Assistant Representative	UNFPA
8	Ramlat José	GF Project Coordinator	UNDP
<b>Group discussion with WHO</b>			
1	Danielle Cavalcante	Programme Manager Officer	WHO
2	Eva Pascoal	Officer in Charge	WHO
3	Fernanda Alves	Communicable & NCDs	WHO
4	Mateicio D' Almeida	official SRMNI	WHO
5	Nzuzi Katondi	NNO/TVD	WHO
<b>Group discussion with UNDP</b>			
1	Adolfo Cambule	Advisor/Provincial Liaison	UNDP
2	Edo Stork	Representative	UNDP
3	Fernando Damázio	Project Officer	UNDP
4	Mamisoa Rangers	Deputy Country Representative	UNDP
5	Ramlat José	Global Fund Project Coordinator	UNDP
6	Tânia Lourenço	Data Comp. Team lead	UNDP
<b>Group discussion with UNICEF</b>			
1	Frederico Brito	Chief, Health & Nutrition	UNICEF
2	Hirondina Cucubica	Health Officer	UNICEF
3	Ivan Yerovi	Representative	UNICEF
4	Yaozhu Chu	Planning, Monitoring & Evaluation Specialist	UNICEF

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