Mid-term review of inter- sectoral response to HIV/AIDS in Angola

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NORAD

MID-TERM REVIEW OF INTER-SECTORAL RESPONSE TO HIV/AIDS IN ANGOLA

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ECONOMICS • FINANCE • SOCIOLOGY • RESOURCE • MANAGEMENT

Abbreviations

AAVIHDA	Association of the Friends of HIV DA
ADPP	People to People Assistance (NGO)
ADRA	Action for Rural Development and the Environment (NGO)
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
ARVT	Anti-retroviral therapy
ATMS	Association of Middle Level Health Technicians (NGO)
CAN	African Championship Cup (soccer or handball)
CATV	Voluntary Counselling and Testing Centre
CCF	Christian Children's Fund
CUAMM	Doctors of the World (NGO)
DFID	Department for International Development (UK)
DPS/PDH	Provincial Directorate of Health
GDP	Gross Domestic Product
GOA	Government of Angola
HAMSET	HIV/AIDS, Malaria and TB Control Project
HIV	Human Immuno-Deficiency Virus
IEC	Information, Education and Communications
INLS	National Institute for the Fight Against AIDS
IRHA	Inter-Sectoral Response to HIV/AIDS in Angola
KAP	Knowledge Attitudes and Practices
KABP	Knowledge, Attitudes, Behaviour and Practices
LAN	Local Area Network
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PLWA	People Living with AIDS
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
RAAP	Rapid Assessment, Analysis and Action Plan
STI	Sexually Transmitted Infections
UN	United Nations
UNICEF	United Nations Children's Funds
USD	United States Dollar
VCT/ATV	Voluntary Counselling and Testing
M&E	Monitoring and Evaluation
YFHS	Youth Friendly Health Services

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EXECUTIVE SUMMARY

Sweden and Norway entered into an agreement of nearly USD 8 million with UNICEF on *"Inter-sectoral response to HIV/AIDS in Angola"* (IRHA). The goal of the 2006-2008 Programme is to improve the survival, safety, health, and social acceptance of children and youth affected by HIV/AIDS, with a particular focus on girls and young women.

The Angolan context is special in at least three respects:

- The comparably low prevalence of HIV/AIDS (4-5%) compared to much higher rates in neighbouring countries,
- The comparably high – and increasing rapidly - GDP per capita of USD 4-5000, and government spending on health and education that is much higher than other African countries.
- The absence of reliable baseline population data and subsequently, consequently for all human development indices measures, including HIV/AIDS prevalence, etc.

  The IRHA budget has four substantive subcomponents totalling USD 6,080,000 plus additional allocations of USD 1.7 million making a total of USD 7.7 million.

Conclusions

a) The programme as a whole has made a significant contribution to fighting HIV/AIDS in Angola. It successfully matches the country's needs as presented in the government's Strategic Plan with UNICEF's mandate, in particular through its decision to focus on youth-oriented prevention.

b) Achievement of Objectives. The programme appears to have made a positive contribution to the various objectives that could be attributed to it:

- Building institutional capacity: yes, through support for the local health authority in Cunene through its ongoing work with INLS and contributions to national guidelines, its work with ministries on mass campaigns and schools-based programmes and the communication strategy that could have some important institutional and public education implications.

- Reducing the incidence of HIV/AIDS: yes, there is a strong probability of impact in the most seriously affected Cunene province through the concentration of mutually reinforcing projects. Potentially also yes on a wider scale if the in- and out-of-school youth campaigns succeed in being retained and acted upon by the Angola authorities in particular but also civil society.

- Mitigating socio-economic impact: Not through the single pilot initiative although other activities aspects of the programme such as the clinical/outreach and paediatric AIDS support must also have helped.

- Improved survival, safety, health, social acceptance of HIV-AIDS affected: As regards "survival, safety and health" probably good impact in the provinces where the programme has a geographical focus with mutually reinforcing components, as in the case of Cunene. "Social acceptance" is more complex as it requires a long slow haul

rather than a quick fix. Nevertheless, the programme provided strong "kick-off" support with its youth-directed saturation campaigns and this is being complemented by its support for more systematic awareness raising of the grass roots type through life skills clubs as well as support for PLWA.

- The stated goal feature of "a focus on girls and women" was not achieved. Many activities had inherent gender aspects but this is not the same as pro-active initiatives. Only two out of 39 indicators had specific gender targets and they were for the only gender-based project – that was dropped. .In the many meetings on AIDS issues no informant referred to homosexuality as an issue or cause, and gender-based violence was not addressed specifically in the programme.

c) Various aspects of the programme as implemented are different to what was presented and agreed in the programme proposal document. This in itself is not necessarily a negative feature. The need for flexibility is the necessary corollary of the many, often unpredictable factors inherent to the programme's complex context and its scope. And on the whole the changes are relevant to the overall objectives. Nevertheless, there should be more documentary justification for such changes. In addition, donors and UNICEF need to reconcile agreements, budgets, spending and reporting in order to establish whether actual execution and reporting meet agreed targets, and whether field implementation costs, recovery costs and budget deviations are within agreed levels.

d) The programme's weakest points are its monitoring and reporting shortcomings. Each of the 20 or so projects/activities had indicators and narrative reporting obligations and the programme document lists various monitoring tools (reports, sentinel sites, youth KAPB surveys and "project monitoring") but without any indication as to which would be used where and for what purpose. The IHRA programme document contains a list of around 40 mainly quantitative indicators, with no targets and no appropriate means of verification other than "project monitoring". The annual report to donors is a matrix based solely on these indicators where IHRA outputs are mixed with non-programme figures and there is no narrative text analysing the results or placing them in the right context.

   Financial Reporting also presents some problems for programme monitoring. UNICEF has a rigorous financial management system but for programme monitoring the disaggregation of the detailed statements stops at the budget line. There is no system for grouping related items by project. This is a management issue. Without a being able to match (financial) inputs with (project) outputs it is not possible to draw any conclusions about efficiency.

e) Sustainability is not a major issue for pilot projects as GOA should be able to take over whatever is found to be successful. However, there are signs that the scale of big campaigns could be considerably reduced in future. Faith-based groups may be able to continue the IRHA life skills activities but NGOs may find it more difficult as they have limited alternative resources. Moreover, it seems that projects requiring a three-year time frame rather than the two years funded by the IHRA programme may have a problem. This raises the issue of UNICEF's engagement in projects requiring a medium-term time frame, when it cannot enter into commitments for more than two years.

f) Much of what has been achieved under the programme is due the dedicated and hardworking UNICEF staff and the organisation's good working relationship with its partners.

Lessons Learned

a) For proper project management, monitoring and evaluation of such a complex programme a clear project document is essential, with a strong LFA programme structure with not only stated objectives but also outcomes (as the basis for identifying relevant indicators and) and that includes an appropriate and relevant monitoring system built around baseline data and/or descriptions and where among other aspects, achievements can be measured against costs. Good monitoring capacity is particularly important when programmes include pilot activities and learning.

b) There is a need to strike a balance between providing sufficient information for M&E purposes without making UNICEF's management and monitoring work too onerous.

c) While there is a need to allow for a degree of flexibility, the agreement should define clearly the degree of latitude and the point at which the donor needs to be consulted and/or provide authorisation for major changes in the agreed programme.

d) The monitoring system must be able to address two levels: the individual projects that comprise the programme and the programme's impact on the nationwide problem to be addressed, for example, by combining the random selection of individual projects for in- depth monitoring with a more general evaluation of the overall programme. This requires two sets of indicators – for projects and for the programme. In addition, in both instances indicators need targets and targets need a baseline. In cases such as Angola where there is no real reliable baseline information, at least the best "guesstimate" should be identified.

Recommendations

As there is less than one year left no major reorientation of the programme is possible or recommended. However:

a) Based on existing agreements UNICEF should clarify with donors the areas with substantial changes in the programme's content and its budget, issues related to the cost level of Field Implementation and Operations and Recovery Costs, and the structure of remaining reporting.

b) UNICEF should revise its M&E set-up[1]. This should start by specifying the intended outcomes (even if the same as for the UNICEF programme as a whole or its youth and HIV component) in order to better focus outputs and thus indicators with realistic targets. Moreover, the means of verification should be clearly identified i.e. the monitoring

[1] Frequent field visits are not in themselves indicative of a monitoring system; a field visit is merely **one instrument** of such a system where they must have a pre-determined role in terms of purpose, data collection, verification, feedback etc.

instrument to be used in each case. It is also recommended that in the event of a future programme of this nature if possible during its preparation UNICEF staff should receive external assistance in results based programming.

c) Given the importance of information in monitoring the current programme and in order to support the government's monitoring capacity assistance the programme should assist in the development of databases that help overcome the GOA's information deficit.

d) The financial reporting system should be revised in order to facilitate better monitoring and reporting of expenditure by project and component.

e) UNICEF should focus on activities that assist the government in terms of protocols and procedures that reduce the stigma of HIV/AIDS and promote its prevention and treatment in clinics as "one of many illnesses". The ADDP and ADRA projects should also be carefully looked into in this respect to assess whether they contribute to the stigma or not.

1 INTRODUCTION

The Norwegian Embassy entered into agreement with UNICEF on "Inter-Sectoral Response to HIV/AIDS in Angola" on 15 June 2006. The agreement runs from 2006 to 2008 and has a maximum financial value of NOK 20 million. The Swedish Embassy entered into an agreement with UNICEF on the same program in December 2005. The Swedish grant totals SEK 35 million.

Article 8 of the agreement states that *"an independent mid-term review will be agreed upon by UNICEF, MFA and other donors. It is recommended that the review take a sector wide approach."* Terms of Reference for the review are included in **Annex 1.**

The assessment of the UNICEF programme was based on desk and field studies of some 20 or so projects/activities (the number differs in different reports), including 9 days of field work in Angola, of which 3 days in Cunene province, as well as studying some 20 projects supported with grant funds. Various constraints hampered the team's ability to reach a well-fundamented assessment of work and achievements under the inter-sectoral programme, its effectiveness and efficiency:

The grant's hybrid features: on the one hand it is used to support projects and activities that fall under four priority thematic areas identified in the agreement, and which are drawn from the UNICEF Country Programme. This latter feature, however, means that the grant is also of a budget support nature, a financial contribution to a country programme (and its overall targets) that also receives inputs from other sources. Consequently, the attribution problem means that it is not possible to assess the programme's contribution to the wider UNICEF goal and objectives.

Related to the above is the programme's monitoring and evaluation set-up: the absence of adequate monitoring reports and predominantly quantitative output indicators contribute little to an assessment of qualitative impact.

For these reasons the assessment is based mainly the triangulation of project reports, interviews/meetings and field impressions. Although this is not a very good basis for "scientific" fact-based conclusions and recommendations the team feels that it is nevertheless a reasonably accurate depiction of the programme and its status.

The focus in the review on project and financial management, and monitoring, is in line with that of the Norwegian Government.

2 BACKGROUND

2.1 Socio-economic context

The socio-economic and HIV/AIDS background of Angola is given in **Annex 2.**

After decades of civil war Angola finally achieved peace in 2002.

Post-war developments have included a 2007 law introducing a gradual process of decentralisation, deconcentration and transfer of resources to sub-national governments. Their organisational structure will include collegiate and singular organisations including, at municipal level, a Provincial Council for Hearings and Social Conciliation. Although there are still many aspects to be worked out, including as yet un-clarified distribution of social and educational powers between the provincial and municipal levels. Nevertheless, no matter what the outcome it could be highly relevant to the pursuance of a dynamic HIV/AIDS programme (or not as the case may be).

Since 2002 the combination of peace, higher oil production and prices, revenue from diamond production, some economic reform measures and heavy investment in the reconstruction of the country (starting with road and rail communications and the provision of basic premises to house government services in order to reintegrate previously isolated areas) have resulted in a strong, more broad-based economic recovery that includes the non-oil economy. As some people move back to their home areas agricultural output is increasing.

Between 2005 and 2007 in particular, the country experienced major transformations. The education and health budgets rose roughly 2.5 times and social welfare allocations even more so. In 2007 education accounted for 5.6% of the budget, health 3.7% (6.7% in 2008) and social and welfare 10.6%. Even though this represents slippage compared to the previous year, in absolute terms expenditure it is still considerably higher than in many other countries: in 2005 per capita expenditure on health was US$29 and the approved budget for 2008 health represents USD 164 per capita.

Nevertheless, it is clear that the efficiency and effectiveness of public services still leave a great deal to be desired. This is hardly surprising given that progress in this field requires not just physical infrastructure but the appropriately trained manpower and also the updating of policies, guidelines, curricula etc. These take a long time to come to fruition, and the processes are much more complex and protracted than the construction of a school or health post.

In conclusion, given Angola's enormous domestic resources it does not require substantial financial assistance from donors. What it does need, however, is technical assistance in a variety of sectors and roles so that its financial and human resources are made as productive as possible.

2.2 The AIDS Context

Despite strong reservations about the reliability of statistics due to low coverage (only a few surveillance centres), it is widely acknowledged that Angola has a much lower prevalence of HIV/AIDS, around 4-5 %, than other countries in Southern Africa. This is unusual given the country's history of war with large contingents of armed forces scattered around the country

and the destruction of health services and facilities.

In 2006 (a year after a nationwide AIDS in Education campaign, see below) a KAP survey by PSI among the 14-18 age group in 6 provinces found substantial geographical and gender variations. Overall, 99% of those interviewed had heard about AIDS and 77% thought it was a serious problem, but while the level was 100% of the total in Luanda it was only 63% in Lunda Sul province.

The survey also found that for many informants "hearing about AIDS" was the limit of their knowledge: some 90% of informants did not know the three key methods for protection, in particular the big uneducated group of informants compared to the educated group.

Various past and present features of the Angola situation provide fertile ground for the spread of the disease:

- Initially, during and immediately after the war troop movements and population displacement within the country and across its borders with neighbouring countries with a high incidence of HIV/AIDS;
- rapid urbanization coupled with poverty, driving the sexual exploitation of women and children as sex workers;
- peace brought more traffic along road corridors expanding the threats presented by high risk candidates such as lorry drivers;
- inadequate coverage by the National Health System;
- cultural factors: a tradition of early sexual relations from the age of 15 onwards (45% of the PSI survey informants), the inferior status and power of girls and women, and multiple partners relations between young girls and much older men (the PSI survey found that the average age of partners of a 24-year-old woman was 39);

In addition, even when there is knowledge of the danger of unprotected sex this is not followed through. According to the PSI survey almost 70% of informants practiced unprotected sex, 42% were unconcerned about getting infected and only 9% were aware their behaviour was high risk. The most vulnerable groups were those with little education, girls and the younger informants.

The major transformations experienced by the country between 2005 and the end of 2007 were reflected in the AIDS situation:

- With the conclusion of the country's war-to-peace transition, the government was able to turn its attention to an intensive development programme;
- With ample funds from the oil windfall, work started on a massive infrastructure programme that on the one hand included expansion of the health network but on the other hand opened up communication routes, bringing the possibility/probability of conducive conditions for the spread of HIV/AIDS e.g. transport corridors
- In addition to physical reconstruction there was considerable progress in policy and strategy formulation;
- As regards HIV/AIDS , these developments meant that government was able to make a qualitative leap from a somewhat passive stance to pro-active engagement in both prevention and in clinical support for PLWAs;

In December 2006 GOA published a new "National Strategic Plan for the Control of Sexually Transmitted Infections, HIV and AIDS: 2007-2010 (SP). Prepared through a participatory

process[2] the SP contains a detailed report on achievements under the previous 2003-2006 programme. It establishes targets for universal access to prevention, treatment, care and support for PLWA as well as the objectives and priorities to be observed by all relevant programmes in the country**. Annex 4** contains a summary of the plan.

The plan has three general objectives:

- To strengthen the capacity of the national response in the fight against HIV and AIDS;
- To reduce the spread of the HIV epidemic;
- To mitigate the socio-economic impact of HIV and AIDS on the individual, the family and the community.

The content is similar to the previous plan, with two exceptions: the inclusion of a monitoring and evaluation component and a vertical transmission component. The plan has the four components shown below in Table 1 together with the budget.

Table 1: Summary Budget - Government of Angola Strategic Plan 2007-2010
USD million

Component	2007	2008	2009	2010	Total	%
1. Strengthening Management	2.2	5.4	4.1	5.8	17.5	8%
2. Promotion and Prevention	21.0	15.2	22.0	13.5	71.6	35%
3. Assistance	13.8	20.8	30.0	42.4	107.1	52%
4. Care and Support	1.3	1.9	2.8	4.9	11.0	5%
Total	**38.2**	**43.4**	**59.0**	**66.6**	**207.2**	**100%**

The main subcomponents and activity areas are:

Strengthening Management: INLS, national and provincial committees; articulation with civil society, epidemiological surveillance, M&E – receives 8 % of the planned funds

Promotion and Prevention: Vulnerable and target populations; campaigns and education material; condom promotion; voluntary counselling and testing; stigma, safe blood and vertical transmission – receives about one third of the planned funds

Assistance: access to services, ARV drugs and opportunistic infections; TB/HIV opportunistic infections; laboratories; STI – receives the biggest portion, over half the planned funds

Care and Support: Affected children; people living with HIV/AIDS – receives 5% of the planned funds.

2.3 Overall HIV/AIDS Assistance and UNICEF

In recent years the number and volume of programmes addressing HIV/AIDS have risen considerably. In addition to the Norway-Sweden contribution to UNICEF, in late 2005-early 2006 two major new programmes were launched: the Global Fund administered by UNDP and the World Bank Hamset programme, bringing not just funds but also technical expertise and experience. DFID is also providing assistance.

Table 2 shows the anticipated contributions to the government programme as presented in the strategic plan.

Table 2: Government Strategic Plan – Total Funding by Component 2007-2010

[2] Involving deputies, the central government, provincial authorities, NGOs, cooperation partners, UN agencies

USD million

Components	Gov. budget	Global Fund	World Bank	Other	Total	%
Strengthening management	9.0	6.4	1.9		17.5	8%
Promotion and Prevention	43.9	18.1	8.8	0.75	71.6	35%
Assistance	60.7	45.6	0.5	0.30	107.1	52%
Care and Support	4.6	4.8	1.6	1.0	10.9	5%
Total	**118.4**	**74.9**	**12.9**	**1.0**	**207.2**	**100%**
%	57%	36%	6%	0.5%	100%	

GOA will finance somewhat over half the cost and the Global Fund a little over one third.

The period covered by the strategic plan is 2007-2010 whereas the duration of the UNICEF Inter-sectoral Response to HIV/AIDS in Angola Programme is 2005-2008. Its budget and time frame are summarised in Table 3.[3]

Table 3: Inter-sectoral Response to HIV/AIDS in Angola Budget
USD million

Components	2005	2006	2007	2008	TOT	%
Policy development, capacity building	0.07	0.245	0.29	0.145	0.75	10%
Prevention thru schools + communities	0.48	0.78	0.78	0.77	2.81	36%
Orphans and Vulnerable Children	0.02				0.02	0.3%
Clinical + outreach services	0.58	0.61	0.64	0.67	2.5	32%
Monitoring + Evaluation	0.035	0.08		0.13	0.245	3%
Sub Total	**1.185**	**1.715**	**1.71**	**1.715**	**6.325**	**82%**
Field Implementation/Operations	0.116	0.178	0.183	0.178	0.655	8%
Recovery Costs	0.143	0.208	0.208	0.218	0.767	10%
Total	**1.444**	**2.101**	**2.101**	**2.101**	**7.747**	**100%**

The UNICEF components more or less match the plan's structure and priorities although a direct comparison is not possible as the Strategic Plan's equivalent to UNICEF's 18% "administrative overheads" is not visible.

The management/institutional development and prevention components of the two programmes account for similar proportions of the overall budget, but the strategic plan assigns proportionately more to assistance/clinical outreach (over 50%) than UNICEF (32%).

[3] Although budgeted for in 2005 the programme only started in 2006.

3 MAJOR FINDINGS AND ASSESSMENTS

3.1 The "Inter-sectoral Response to HIVAIDS in Angola" (IRHA) programme

As presented in the Project Proposal the programme is a hybrid mix of

a) budget/sector support for the HIV/AIDS component of the UNICEF Country Programme in Angola. The proposed sector contribution covers four areas that are in line with the country's priorities as laid down in its strategic plan although the weight is slightly different. This reflects the difference between the SP's broad coverage and UNICEF's more focused "women and children" mandate and its HIV/AIDS target areas: primary prevention, paediatric AIDS, prevention of mother to child vertical transmission and protection for orphans and vulnerable children. Given the special characteristics of Angola there is a special emphasis on primary prevention among youth in particular. The review team considers the planned allocation to be appropriate to the Angolan situation.

b) project support, with the funds allocated to about 20 specific projects or discrete activities, each with its own projects document and set of indicators that form the basis for monitoring the programme. The eventual project composition of the IHRA programme was the result of ongoing Government or UNICEF initiatives requiring continued funding, new activities or projects awaiting funding in order to be implemented or upscaled, discussions with government and civil society partners and a flexible response to unforeseen opportunities or requirements.

The projects and activities identified by the review team are presented in **Annex 5**.

One of the team's main concerns was to identify how the content of this project mix matched the budget content and structure presented in the original proposal and in annual work plans. This involved a comparison of the planned and actual expenditure followed by two approaches: joint working sessions with programme officers and finance staff and a study of the line items in the detailed statement of programme payments during preparation of the report.

However, both were rapid exercises aimed at obtaining a rough picture of the situation, and should in no way be considered a detailed, accurate budget analysis. Table 5 compares the budget with committed expenditure for main components.

Table 5
Comparison between the Programme Budget and actual Spending
USD[4]

Activities	Budget	%	Real Expenditure*	%
Policy Development, Institutional Capacity Building	**750,000**	**12**	**469,677**	**10**
Technical support for policy, procedures etc.	335,000	6	437,720	9
HIV Seminar and Youth Forum	300,000	5	6,957	0
Provincial + national planning and training	115,000	2	25,000	1
HIV prevention through schools and communities	**2,810,000**	**46**	**2,580,306**	**55**
Campaigns in schools: materials and training	410,000	7	269,612	6
In-school clubs, out of school youth: training, youth, radio	930,000	15	508,694	11
Out of school youth: supplies, training, communication	1,470,000	24	1,802,000	39
Orphans and other vulnerable children	**20,000**	**0**	**0**	**0**
Situation assessment of OVCs	20,000	0	0	0
Clinical and Outreach Services	**2,500,000**	41	**1,609,740**	35
Creation/expansion services/facilities	830,000	14	817,013	18
PMTC supplies	1,105,000	18	588,137	13
VCT and STI supplies	410,000	7	101,526	2
Training	155,000	3	103,064	2
TOTAL Projects and Activities	**6,080,000**	**100%**	**4,659,723**	**100**
Monitoring and Evaluation	**245,000**			
Post campaign assessments	35,000		5,128	
Household health survey	80,000			
End of project KABP survey	130,000			
Field Implementation and Operations	**654,280**		**778,323**	

* "used as of 31/12/08" according to the UNICEF table presumably means "committed". The figures given in the table differ slightly from those given in Annex 3 Monitoring Sheet Summary.

Table 5 shows that the committed used resources as of end 2008 will be USD 1.4m less than budgeted. The proportional expenditure under the various headings was more or less as planned, the main differences being a rise in the proportion of funds spent on prevention activities, from 46% to 55%, and a fall in clinical/outreach services, from 41% to 35%. In relative terms UNICEF is using the funds for the agreed purposes. However, for individual budget lines there are substantial deviations, like a usage of:

Only 60% of planned on Policy Development, Institutional Capacity Building
Only 64% of planned on Clinical Outreach and Services
Only 2% of planned on Monitoring and Evaluation (the largest item is for an end of project KABP survey).

Another simple way of verifying the programme's consistency and appropriateness is to see whether the various projects are in compliance with the four activity areas that, as already shown, are compatible with the strategic plan's four components. Using the information contained in **Annex 5** the result is shown in Table 6.

[4] The percentage distribution of the components is slightly different to that in Table 3 as it excludes M&E and Field Implementation and Operations

Table 6: IHRA Projects by priority areas/components

Policy Development/Institutional Capacity Building	• DPS Cunene • Communication Strategy
HIV Prevention schools and communities	• Awareness campaign in schools • Youth In Free Time campaign • Total Control Epidemic ADPP • Life Skills Benguela Caritas • 6 other Life Skills Projects • Radio against SIDA, Cunene
Orphans + Vulnerable Children	• Total control epidemic Cunene ADPP • Support HIV children Paediatric Hospital Luanda AAVIH • Counselling Paediatric Hospital Luanda CCF
Clinical Outreach Services	• Prevention Benguela Medicus Mundi • Prevention Benguela ATMS • Control HIV Cunene CUAMM
Other	• Impact Mitigation ADRA • Life is stronger than AIDS PLWA

However, a different picture emerges when examining the content of the projects and activities rather than just their "titles". In order to systematise the data available from various sources the review team prepared a summary indicator progress/status information table (see **Annex 6**) drawing on information contained in the programme proposal, the two matrix-based annual reports, other documentation consulted and from meetings and interviews.

The purpose of the table is to provide a more comprehensive picture of the work done than is provided by the matrix reports, where:

- Achievements in the first year are sometimes repeated in the second;
- Achievements and statistics sometimes refer to global or national figures rather than the those of the IHRA programme and the distinction is not always clear;
- Most importantly, the quantitative statistics emphasis loses important contextual information, conceals justifiable reasons for what may appear to be unfounded changes and may cause some important gains or achievements to go unreported;
- The annual reports introduce a new category with its own indicators – Information, Education and Communication – that is only included in a part of the programme document, and not included in its budget or the financial reporting table. This may be for the obvious reason that these activities served more than one programme output, but when not contemplated as such in the original programme proposal it just serves to cloud the picture of what actually happened and why.
- The annual work plans have a different description of activities as compared to Programme Proposal and financial reporting.

The table presented in **Annex 6** "Systematic Progress Report" is organised by programme component and the respective outputs[5].

For each indicator there is a brief text summarising the situation as understood by the review team (with occasional gaps or question marks where the information was missed or is unclear in the team's copious notes). This will hopefully provide a fuller and clearer picture of the work done by UNICEF and the application of IHRA funds in a difficult context requiring considerable flexibility - that can sometimes result in substantial unplanned/unintended changes, but that nevertheless are acceptable in the circumstances as they make a positive contribution to the programme's objectives.

Annex 6 has an attachment that attempts to group the individual payment items by project or activity area in order to get an idea of how much was spent and in particular on what for each project/activity area. Although it does not include all the relevant payments it gives some idea of what really happened. For example, it shows that:

- Some $470,000 were spent under Component 1 "Policy development and institutional capacity building" (about 62% of the planned budget). Very little of the expenditure had anything to do with this subject. USD 54 000 was spent on international seminars/meetings (that could be considered training/institution building) and over $78,000 on the communication strategy – policy/institution building although not of the technical protocol/guidelines type that could have been expected.
- lines 02 (HIV seminar and Youth Forum) and 10 (supplies for VCT and STI services) became "miscellaneous" lines
- Line 011 (Trainings) became a budget line for PLWA
- Lines 05 (equipment HIV clubs, radio programme) and line 06 (Supplies, Training and Communication materials out of school community model) had many interchangeable items – understandable as dealing with related subjects

The following picture emerged from the similar, unfinished exercise with UNICEF staff, matching individual expenditure items to activities. Some expenditure items such as "Material for HIV Campaign, Children in Spare Time"[6] (USD 240 000 + USD 44 102 + USD 8 400), Printing of Leaflets (USD 12 890), Music CD Young Artists (USD 12 500), etc are part of the IEC programme component, but recorded as individual expenditure items under budget line 06 *(Supplies, Training and Communication Materials for out-of-school Community Model"),* under the component "HIV Prevention through Schools and Communities".

However, overall and despite some changes of emphasis in its different components there can be little doubt that the programme as a whole has made a useful contribution to fighting HIV/AIDS in Angola. It successfully matches the country's needs as presented in the government's Strategic Plan with UNICEF's mandate, in particular through its decision to focus on youth-oriented prevention.

In the team's opinion youth-oriented prevention is the programme's major achievement, fits UNICEF's mission and is in line with government priorities. Moreover, although the funds available to the programme are minimal compared to the other two big programmes (Global Fund and World Bank) it is likely that the two intensive mass campaigns directed at youth had

[5] The UNICEF matrix uses the term "key results" which is incorrect. This is not just semantics as there are M&E implications

[6] Material Campanha HIV Jovens em Tempos Livres

a big impact that was out of all proportion to the funds expended. In addition, the supply of containers and mobile services must have aided the more rapid roll-out of prevention and testing services, particularly for women, although the team was unable to assess this objectively (the baseline data problem again). As regards the all-important ARVT, however, the team was informed that one of the main constraints for the time being is the government's insistence that this can only by prescribed by a physician[7].

As regards the planned and real balance between the components, the IHRA seems to give much more weight to Clinical and Outreach Services than suggested in the UNICEF Country Programme - in particular supplies (drugs, etc) with a budget of USD 1.5m million have a comparatively higher place in the IHRA than in the Country Programme. No doubt supplies were needed initially but considering that such supplies are more of a "money question" (and GOA is much better endowed in this respect than most developing countries) the team feels that the more difficult technical and institutional capacity building could have greater priority. Indeed, according to the financial statements received spending on such items under the relevant budget lines 09 and 10 has been much less than planned - about USD 600 000 under line 09 and nothing under 10 that became a kind of "miscellaneous" bag of items (see the detailed lists attached to Annex 6).

Finally, as already mentioned, in addition to the baseline data problem it is difficult to assess the impact of the IHRA programme on the HIV/AIDS situation in the country as a) it is part of a broader UNICEF effort in this field and b) many other relevant multilateral and bilateral programmes are contributing to the same end.

3.1.1 Policy development and institutional capacity building

The main items planned for this component were technical support for the production of new treatment protocols and guidelines and the respective staff training, technical assistance for the design and dissemination of IEC materials for youth, the roll-out of provincial action plans, a seminar for the inter-ministerial commission on AIDS and the respective staff training, the production of provincial plans, a national HIV seminar and gender training for women (vendors and "women of influence").

This last item, training for women, arose as a possibility during the preparation of the programme but was subsequently considered unviable. The national seminar did not take place and the design of IEC materials was funded primarily under the youth component. Little was funded in relation to the rollout of provincial plans or technical policy/protocol contributions and guidelines, for two main reasons. Firstly, some of this work was taken up by other donors, especially Brazil. Secondly, technical input to the various STI, VCT, PMTCT guidelines was provided mainly by UNICEF line staff without any special IHRA funding.

Their contributions have included guidelines on feeding HIV/exposed infants, a prominent role in a working group on home based care and the needs of primary health workers. There has also been very active advocacy on a subject of extreme importance for the both the welfare of mothers and children and AIDS prevention: promoting an integrated approach to HIV/AIDS and primary health care. However, this is being addressed in the Clinical Outreach component, with projects that have somewhat of a pilot nature, providing practical examples of what can be achieved through such an approach.

[7] In other countries e.g. Tanzania, this can now be done by less highly trained (and more readily available) staff.

Consequently, most of the expenditure items planned for the component did not take place, yet $ 470,000 was spent in two ways – on an unplanned but important and much needed communication strategy and on a variety of disparate activities that give the component the air of a residual that accommodates what cannot be justified under other headings.

The communication strategy was prepared through a consultant placed in INLS and a visiting consultant. The draft was concluded in December 2007 and will be presented for discussion in early 2008. The strategy document is a useful contribution to policy development and should result in more consistent and coherent messages and ones that have a more positive tone. The strategy document has an action plan that includes promoting dialogue on HIV/AIDS, training for health and media professionals in communication for social change, and proposals on a pilot project to be implemented in 2008. Unfortunately, the financial reporting system does not permit the easy identification of expenditure on each discrete "sub-component", but a rapid check of the financial statements indicates that expenditure on the communication strategy amounted to around USD 80 000.

Of the remaining expenditure as much as 70% (USD 64 000) of the spending in 2006 was on seminars/training overseas, a national seminar and miscellaneous minor items. While the review team acknowledges that there is an indirect linkage between seminars and training activities that generate new ideas for policies, it feels that the matrix reporting structure does not permit adequate accountability on the use of funds, and does not permit an assessment as to the relevance of these particular overseas travel items to policy capacity building. However, UNICEF informs that the purpose of the overseas travel was to enhance policy development capacity building by exposing government officials to international experience.

Another reporting problem is also evident in this component – the inclusion of items that were in the plan, but where in practical terms the IHRA contribution (financial at least) was minimal ($ 1,500 - $3,700 each):

- "17 provincial action plans have been developed", reported not only in 2006 but also in 2007
- "UNAIDS, UNICEF and other UN agencies conducted a planning exercise to revise the National Strategic Plan for 2007 – 2009", and
- "UNICEF in partnership with the Ministry of Youth and Sports started a large campaign *Youth in their free time*" (stated in the matrix section for the abandoned "women leaders and market vendors" activity).

It is the opinion of the Review Team this kind of reporting is misleading as to the real role of the IHRA programme. Nevertheless, UNICEF considers that "softer" programme components such as provincial planning exercises and joint work with other agencies made important contributions to the programme by creating a new working environment and introducing sub-national planning. The review team agrees entirely, but questions whether these activities occurred predominantly under the IHRA programme being evaluated.

3.1.2 HIV prevention through Schools and communities

This is by far the biggest area in terms of volume and range of activities and expenditure. It involved a massification, saturation approach, bombarding young people with information from a variety of directions with two major campaigns, one targeting in-school and the other out-of-school children.

In 2005 UNICEF helped the Ministry of Education to prepare and implement a big **AIDS**

awareness campaign in the country's secondary schools under the slogan "I defend life by learning about AIDS". The core event was the inclusion of an intensive AIDS and sexuality-gender curriculum over a period of two weeks[8] surrounded by 3 months of complementary activities. The programme involved the production of two manuals for every student as well as training trainers and teachers. Over 600,000 students and 9000 teachers participated in the campaign. It was accompanied by radio and television spots, substantial media coverage, special events to mark the opening and closing of the campaign, the creation of school drama groups and a nationwide drama competition. One of the few programs to have an external evaluation, the report concluded that the objectives of the campaign had been achieved by increasing AIDS awareness and knowledge, disseminating information, provoking more discussion on sexuality and AIDS and promoting commitment to removing stigma and discrimination. It had motivated people, encouraging them to do something about HIV/AIDS.

This information is provided in the IHRA report for 2006, the programme's first year, and during its meetings the review team also got the impression that the IHRA programme had made a substantial contribution to the school campaign. Yet it took place before the programme became active.

The following year UNICEF helped the Ministry of Youth and Sport to reach out of school through a **Youth in Free Time campaign**. UNICEF funded a short-term consultant within the ministry as well as the media NGO, BBC World Trust, as a consultant to both design the program's content and organize much of it. Launched in June 2006, the campaign targeted young people aged 15 - 19 through the places they frequent, the activities they enjoy: videos, music, artistic and sporting activities, music festivals, radio and television edutainment programs (including a specially designed quiz) and the people they admire: singers, DJs and personalities. The campaign also involved the production of large quantities of youth friendly publicity materials from its own catchy logo to posters, T-shirts, caps, a CD of AIDS-themed songs by some of Angola's best known musicians and the country's first documentary film on people living with AIDS. It also took the opportunity to promote messages through some major sporting events: the national handball championship, the African basketball championship (Afrobasket) and preparations for the Soccer Africa Cup (CAN). There was strong collaboration with civil society, in particular networks of people living with AIDS, the first time they had been given national prominence and a nation-wide platform to denounce stigma and discrimination and what it meant to them as individuals.

An important spin-off from the education campaign was the creation of extra curricular "**School Youth Clubs**" devoted to gender and HIV/AIDS, supported by facilities provided by the school and teachers trained in promoting peer support. In 2006 there were clubs in all schools also with varying degrees of activity and engagement; the current situation is unknown. The Ministry of Education has recruited a consultant to develop a database on the clubs.

The aim of the **UNICEF Life Skills Project** is to help young people cope with the challenges of AIDS and is a good example of UNICEF's ability to pick up a successful experience and roll it out. For some years (prior to the IHRA programme) UNICEF supported an AIDS-related life skills education programme run by the Roman Catholic agency Caritas. Its programme and training manual were adapted by UNICEF to make them more relevant to other youth groups. Under the IHRA programme, and supervised by a UNICEF program officer, six faith-based organisations are now running life skills programs, in each case with

[8] with all secondary schools across the country teaching the same curriculum at the same time

some further adaptation to their particular needs in terms of "skills" to be transmitted, although always with an AIDS-gender core. The team had the opportunity to attend a lively and varied[9] hour-long session run by the United Methodists church on "AIDS myths" attended by some 60 teenagers, with more or less even numbers of boys and girls (and girls participating actively in the discussion). It was clearly an enlightening and enjoyable experience for the participants. The programme is intended to run for one year with weekly one-hour sessions every Sunday morning covering a range of topics that include HIV-AIDS, gender, conflict resolution and human rights.

The Review Team finds that the component *"HIV prevention through schools and communities"* is a major contribution to primary prevention, albeit with one reservation. UNICEF admits that even in this core programme component, it is difficult to reach the main IHRA target group – girls and young women. Men and boys still tend to predominate in out-of-school activities (although less so in church-based youth groups) as they can move around more freely. Moreover, although the UNICEF Programme Coordinator keeps track of activities, and will increase monitoring through regular recording of activities and achievements, it was not possible for the Review Team to confirm the number of adolescents, youth and school children reached stated in the Progress Reports, including the gender composition.

The use of funds for the subcomponents under this main heading shows that:

- Budget line 04 *"HIV campaigns in schools, - educational material and training"* (USD 270 000) was only used in 2006, mainly for training *"National Teacher and School Directors" (USD 260 000).*
- Budget line 05 *"Materials, equipment, training for School HIV clubs/Out of School Youth, etc)* (USD 508 000 used) was used mainly in 2007 (74% of total budget) for the intended items and activities. The biggest single expenditure items are Training of Peer Educators (two items totalling USD 137 000), and the salary of the UNICEF Programme Coordinator (USD 61 000)
- Budget line 06 *"Supplies, training and communication materials for Out of School Community model"* (USD 1 887 000 used) was the largest expenditure item.

The expenditure items listed in the three budget lines under the "HIV Prevention through Schools and Communities" component are considered relevant and justified with the exception of a few small items. The main concern regarding this component is the issue of rigour in reporting and accountability problem. As already noted, the progress report states that *"In 2005 an estimated 600 000 students were sensitised on HIV"* yet the IHRA programme only came into effect in 2006.

These are, however, minor comments compared to the main finding and conclusion, namely that the activities under the component "HIV Prevention through schools and communities" reflect the core of UNICEF's mandate, were effective and should be continued and reinforced. The Review Team understands from the Programme Coordinator that monitoring efforts will be scaled up in 2008.

In addition to promoting AIDS awareness on a scale never achieved before, these major campaigns had other unplanned but equally important outcomes:

[9] Including a brief play and a musical interlude

- promoting cooperation between the four Ministry of Education directorates responsible for different aspects of the school campaign e.g. the content of the manuals, social welfare etc;
- raising the profile, commitment and identity of the Ministry of Youth and Sport with a regard to its not inconsiderable responsibilities and mandate for AIDS and out of school youth, providing it with a "cause";
- promoting cooperation between the various ministerial representatives at provincial level;
- promoting innovative collaboration between the government and civil society; in particular, it gave the PLWA network national prominence for the first time.

It should, however, be noted that this kind of qualitative contribution is lost with the current quantitative matrix-based reporting system.

UNICEF support should have laid solid foundations and experience (communication material and methods) that enable the two ministries to organize such events on an annual basis. However, there are indications that the assumption of ample government resources (and the government's commitments under the Strategic Plan) may be over optimistic. According to UNICEF staff there are signs that in the future such events will be more modest as it will not be possible to mobilize the kind of resources provided by UNICEF on a one-off basis. In addition, in his end of assignment report the UNICEF consultant highlights the difficulty of obtaining the necessary active and constant involvement of Ministry officials who had many other calls on their time. It remains to be seen if the same impetus/momentum can be maintained without a strong UNICEF push or the professional input of the BBC World Trust.

3.1.3 Orphans and other vulnerable children

The budget allocation refers to a "situation assessment of OVCs". However, the Rapid Assessment, Analysis and Action Plan (RAAP) on this topic was in fact financed by the DFID contribution to UNICEF. Once again the IRHA reporting matrix system does not acknowledge this. It merely states "Situation Analysis conducted through the Rapid Assessment, Analysis and Action Plan (RAAP) process completed early 2006" and also refers to a variety of other relevant activities that were not part of the IRHA programme.

The RAAP survey found that government support for interventions that assist individuals and families was very limited; the main protagonists were NGOs and faith based organizations. It also stressed the need for a strategy on mitigating the impact of HIV, but as one element in a more comprehensive social protection policy covering all vulnerable families[10]. In addition to being the province with the highest prevalence, the survey also found Cunene was one of the few provinces working to produce monitoring data.

Yet again the rigid reporting matrix system does not explain that the IHRA funded activities have arisen in part due to the RAAP findings (and the response is funded under a different component of the programme). One outcome was the selection of Cunene as a target province. Another was the ADPP project "Total Control of the Epidemic in Cunene", mapping all households and child vulnerability in the three most densely populated parts of Cunene. Another was the ADRA "Mitigation of the Impact of AIDS" in the same province. Both are funded under the "clinical and outreach services component".

[10] As in many other cases some of the project's findings were compromised by the persistent absence of statistical data.

3.1.4 Clinical and outreach services

UNICEF has financed the rollout of ATV, PMTCT and ART services in Kuando Kubango, Moxico, Benguela, Cunene and Lunda Sul provinces, providing fixed container laboratory and testing and consultation facilities (as a rapid solution to urgent needs)[11], and mobile vehicles to take services to where they are needed. The assistance also includes specialist equipment, staff training and medical supplies. All Benguela's 9 municipalities and 5 of Cunene's 8 municipalities are now covered by mobile facilities. Much of the assistance is being provided through projects run by partner NGOs: CUAMM in Cunene, Medicus Mundi in Benguela and ATMS in Benguela.

UNICEF is using its clinical and material support to promote the desired horizontal integration of primary health services, with this approach gradually being introduced into the services provided by its partners.

Two projects focus solely on Paediatric AIDS. The Christian Children's Fund (CCF) is providing psycho-social support for children infected with HIVAIDS and their families in the David Bernadino Paediatric Hospital in Luanda. It encourages the establishment of Mutual Assistance Groups, educational programmes, and hospital and home psycho-social assistance for some 1000 infected children. A second organisation, the Friends of Life Association (AAVIHDA), is implementing "Project Hope" based in the same hospital. They monitor infected children both in the hospital and at home, in particular to ensure that they stick to the required treatment. The organisation keeps a data base on the children and works with CCF to produce and disseminate information on the services available, including a manual on home care and psycho-social support.

Another project under this component but with a very different focus is support for the Provincial Directorate of Health/INLS in Cunene. It has a strong capacity building emphasis aimed at improving the organisation and quality of services, improving access and supporting IEC activities. In a data deprived country such as Angola, one of the most important elements is support for better quality data collection and analysis by providing IT equipment, training statistics officers and helping to set up an AIDS database. There is also a training programme for community health workers[12].

Under the government's "revitalisation" policy in health in tandem with the UNICEF Accelerated Child Development programme the provincial INLS is mapping three municipalities and dividing them into12 health areas in order to improve primary health service planning and management, as well as the monitoring and coordination of projects and programs. It is collecting data and identifying training needs.

This kind of organisational and technical capacity building at the provincial and municipal levels is fundamental for the government's decentralisation programme. At the same time, however, there has been a conscious decision by UNICEF staff to channel equipment and supplies intended for the Cunene INLS through the central ministry. This not only complied with established procedures but also gave UNICEF the opportunity to monitor the ministries resource management capacity.

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[11] Although with hindsight it was realized that the fixed container solution undermined movement towards the integration of HIV and other primary health services and could undermine the vital confidentiality requirements in consultations.

[12] Originally traditional birth attendants until the Ministry of Health decided to abolish this category of local health worker

The review team concludes that this kind of capacity building at province and municipality level, especially in the province most affected by HIV/AIDS is of the utmost importance.

3.1.5 Targeting Cunene

The IHRA programme is concentrating a number of projects in Cunene as the province with the highest prevalence and as a way of promoting synergies and lessons. UNICEF has placed one of its officers in the province in order to monitor activities there. His physical location in the Governor's Office is an encouraging sign of support for the project at the highest political level in the province.

The projects are:

- Provincial Directorate of Health (PDH): Support for AIDS PVT and Paediatric Treatment
- ADPP: Total Control of the AIDS Epidemic
- CUAMM, Doctors with Africa: Control of HIV Infection in Ombandja and Namkunde municipalities. This project in particular is making a strong contribution to promoting an integrated approach to primary health care and HIV/AIDS services;
- ADRA: Mitigation of the Impact of AIDS in Ombala Yomungo commune, Ombadja municipality,
- Support for the Cunene Provincial Radio

On the whole the review team obtained a positive impression of the work being done by the Provincial Directorate of Health, ADPP and CUAMM. At the Cunene radio station, that had received special training and support for the production of programmes on AIDS[13] the staff seemed to have limited knowledge of the project as such, and complained about insufficient funds for work in the field (per diems and petrol) that were never contemplated in the project. In addition their output appeared rather slim.

As a follow-up to the RAAP the NGO ADPP is being funded to conduct a virtual census in the most densely populated parts of the province. The project has trained 200 field officers who have the task of visiting, documenting, revisiting, promoting IEC and encouraging 2000 people to go for testing over a period of three years (although the IHRA programme is only funding the first two years). The project should obtain detailed and reliable information on the AIDS situation of the 400,000 target population in Cunene. Despite reservations about the militaristic appearance and structure of the ADPP teams and the possibility of their high profile presence reinforcing stigma there is anecdotal evidence that that the project is effective. On more than one occasion the mission was told that attendance at CATVs and PVTCT programmes had risen substantially since the project started.

The Mitigation of the Impact of AIDS project is another follow-up to the RAAP and its findings - the need to identify ways of helping to address the poverty of households infected and affected by HIV-AIDS. The aim is to identify activities that improve the income and well being and thus also the health of communities. The ambitious project, targeting 500 households, includes the provision of improved seeds and tools, mills and animals, the creation of community shops, community committees, the establishment of a revolving fund as well as awareness-raising on AIDS and special programmes for children.

This is the only project where the team has serious reservations about the basic underlying concept. Rural or community development projects require a long-term time frame. Not only

[13] even though the transmitter only covers the capital town and surrounding areas

is the ADRA project very short[14] it involves a complex mix of changing established behaviour and practices, ensuring that inputs do not "kill with kindness" by encouraging attitudes of passive dependence, as well as the financial skills and discipline required when dealing with micro-finance, revolving funds or shops. It will require close monitoring to ensure that the lessons learned (both positive and negative) from the various pilot initiatives are well documented.

The joint UNICEF/Review Team exercise linking detailed expenditure items to main activities seems to confirm that funds were spent on relevant items under this component.

3.1.6 Information, Education and Communication (IEC)

Although the matrix programme reports include IEC as a fifth component proposal, this is not reflected in the financial statement, where IEC-related cost items are recorded under the relevant components.

3.1.7 Monitoring and Evaluation

The Project Document's monitoring and evaluation requirements include the following:

"Data will be gathered via reports, sentinel sites, youth KAPB surveys and project monitoring from schools, VCT centres and outreach health services in 2005 to 2008 to inform the development and improvement of the HIV programme. Research results will be used by the National AIDS Commission and implementing partners to evaluate the HIV strategy and make necessary adjustments in program implementation.

UNICEF has a strong mechanism of monitoring the implementation status of project activities. Staff in country and zone offices will undertake regular visits to project sites to make observations, engage with beneficiaries and local communities, and organize periodic meetings with implementing partners to review the project implementation progress. Some of the indicators that will be used to measure program outputs are laid out in a table on pages 17-18.

Also, a household health survey scheduled to take place late 2006 or early 2007 will include an HIV module that will be supported as part of this project. Finally, an end-project evaluation in 2008 will measure the knowledge, attitudes, behaviours and practices reported by youth and children related to STIs and HIV/AIDS and HIV-positive individuals to assess overall project success."

The IRHA project proposal document has a matrix of about 40, essentially quantitative and output, indicators. In virtually all cases the stated means of verification is "project monitoring". Elsewhere in the document it is stated that data will be gathered through reports, sentinel sites, youth KAPB surveys and "project monitoring" of schools, VCT centres and outreach health services[15]. Little is said about information and sources that permit an assessment of the overall qualitative impact and effect of the IRHA programme as a whole, its contribution to both its own and the strategic plan's general (strengthen the capacity of the national response, reduce the spread of HIV/AIDS, and mitigate its impact) and specific objectives. The project proposal document does, however, refer to "research results" that "will

[14] Unless there are prospects for alternative funding sources after the conclusion of the UHRA programme.

[15] There is also reference to the fact that UNICEF has a strong mechanism for monitoring the implementation status of its "project activities" through regular visits to project sites to observe and engage with beneficiaries and communities and meet with partners.

be used by the National AIDS Commission and implementing partners to evaluate the HIV strategy and make necessary adjustments in program implementation".

The review team will try to give its assessment on the basis of the information available.

Programme approval and monitoring

The programme is governed by Agreements dated 13 December 2005 for Sweden and 15 June 2006 for Norway. These approve the programme content and stipulate disbursement, reporting and evaluation procedures based on the Framework Agreement between UNICEF and Norway.

The Agreements require annual consultations between representatives of the donors and UNICEF to review the progress of the Programme, discuss and approve annual work plans and budgets for the coming year and discuss issues of special concern for the implementation of the program. Representatives of other programme donors should be invited to attend these consultations. There should also be a mid-term review of the programme.

The IRHA programme's monitoring and evaluation instruments and process have a number of failings.

Firstly, the **Work Plan** is little more than a general budget outline comprising the following: (examples from Work Plan 2007):

- Expected Outcomes[16]: e.g. *"Instruments to ensure a unique approach of the activities, in coherence with the national policy of the INLS"*,
- Description/Activity: *"Elaboration of the national HIV/AIDS communication strategy and organisation of consensus workshop"* and *"Production and dissemination of the IEC materials"*,
- Planned Results *"National Communication Strategy and disseminated by the INLS involving all the partners in the struggle against AIDS"*,
- Time Frame (showing which quarters the tasks will be executed),
- Plan/budget (Amount in USD), and
- Source of funds (Sweden or Norway) – should be joint Sweden-Norway.

This is clearly insufficient. A work plan providing the foundations for monitoring would need a much more detailed job or activity description, specification of who will carry out the work and a breakdown of the budget according to the more detailed activity description. One of the activities listed in the Work Plan amounts to USD 556 400 (NOK 3m) but only warrants a two-line "job description": *"Implementation of an institutional programme (health facilities) to improve quality of services (infrastructure, equipment and training for technical staff)"*. The specification of Sources of Funds, i.e. Sweden or Norway, in the Work Plan has no meaning as the funding by the two donors is based on a joint Project Proposal and budget, and funds from both donors are transferred to UNICEF New York and drawn upon by UNICEF Angola from there.

In the UNICEF's comments to the Draft Report it is stated that actual expenditures should be compared to the Annual Work Plan, not to the budget in the original Programme Document. For 2006, when the Programme was started, the combined budget for 2005 and 2006 in the Programme Document is the one used for comparison since logically no other work plan was

[16] Term used in Work Plan

needed for the first year of operation. For 2007 a new Work Plan was developed. Unfortunately this work plan has different headings and project descriptions as compared to those of the Programme Document and to the expenditure statements in the "Joint HIV Project Monitoring Sheet". A direct comparison can therefore only be made for the main Programme components (see table 6 below), and only for some individual projects/activities. Moreover, in the 2006 and 2007 "Reporting for Norwegian and Swedish Government on Inter-Sectoral response to HIV/AIDS in Angola", the attached detailed Funds Utilization Report only adds to the difficulty of comparing since it has a different structure altogether. Therefore, the documents cannot be used directly for comparison of budget and actual expenditures for individual projects/activities.

Secondly, the **Annual Report**[17] is a quantitative indicator-based matrix that often fails to distinguish between progress in the overall UNICEF programme and progress in the Norway-Sweden funded component. However, given that the IHRA funds are applied to discrete projects and activities (all of which with their own indicators for the individual project progress reports) in most instances it should be possible to provide such information – and to distinguish between this data and references to global figures. While in some instances this may be due the core budget nature of the assistance and the contribution of other donors, for the most part the funds have been distributed among discrete projects, campaigns etc. that can be assessed.

Thirdly, the indicators are not structured around any over-riding goal or objective that permits an assessment of the qualitative impact of the IHRA programme on the HIV/AIDS situation in Angola or any of a number of global objectives.

According to the agreement[18] the goal and purpose of the programme are as follows:

Goal: *"To improve the survival, safety, health and social acceptance of children and youth directly or indirectly affected by HIV/AIDS, with a particular focus on girls and young women"*;

Purpose: *"To enhance institutional capacity to ensure rapid, multi-sectoral and decentralised responses to the epidemic; reduce the incidence of STI/HIV/AIDS, and to mitigate the impact of HIV/AIDS on individuals, families and communities"*.

The monitoring and reporting set-up relates neither to this goal and purpose, nor to the following:

The objectives of the government's Strategic Plan: to build national capacity, reduce the spread of the epidemic and to mitigate its socio-economic impact

- Ultimately, the goal of the UNICEF programme in Angola: *"fulfilling the rights of children and women using a human rights approach to programming; to assist GOA in (a) defining realistic targets and strategies ….and (b) strengthening national capacities for revitalising and ensuring the provision of basic services to benefit children and women"*;

[17] The progress reports of 2006 and 2007 (*"Reporting for Norwegian and Swedish Government on Inter-Sectoral response to HIV/AIDS in Angola"*), which have the logo of the Royal Norwegian Embassy (but not the Swedish) and UNICEF on the front page, could be misleading in this respect. Moreover, since these are unique UNICEF reports they should not be "rubber-stamped" by a Norwegian Embassy logo on the front page.

[18] Letters of exchange agreement between the Norwegian Ministry of Foreign Affairs and the United Nations Children's Fund regarding Inter-sectoral response to HIV/AIDS in Angola.

- the outcomes of UNICEF's *"HIV and Youth Project"* in its Country Programme Plan: increased capacity of duty bearers to address the needs of young people, increased access to information and skills for young people, improved capacity of the National AIDS Commission to coordinate interventions
- UNDAF Outcome 3 "*Strengthening of the national capacity for development and delivery of resources and sustaining processes of social empowerment aimed at: ……...(c) controlling the spread of HIV/AIDS*".

Fourthly, the indicator matrix as a reporting instrument is insufficient. What is missing is a narrative report that provides the setting for and analysis of these quantitative achievements, assesses their contribution to achieving the desired results (goal or purpose) and, equally important, documents achievements (or otherwise) not covered by the indicators.

The Review Team feels that the absence of this contextual, analytical information and more structured financial data results in an incomplete picture for proper programme management – and is also a weak source of information for a good Mid-Term Review.

Fifth, the expenditure statements are merely the product of the accounting system, with no subsequent organisation by project or activity in a manner that makes it possible to identify what was spent on each project and/or activity. The list includes the individual payments effected for each of the 15 budget lines. These items range from USD 240 ("mission to Uige") to USD 288 000 ("SSA for BBC Campaign on HIV/AIDS youth in their free time"). In order to understand better how individual expenditure items relate to the achievements for each sub-activity, the Review Team proposed an exercise to allocate expenditure items to each stated sub-component. Whether such an allocation could be done with reasonable reliability was "actively" discussed with the UNICEF staff, and finally an allocation for 2006 was made somewhat in a hurry.

This exercise showed that some results listed in the Progress Report received insignificant funding under the IRHA programme and could not therefore be considered "achievements" of the programme. Annex 5 contains an attachment with financial information based on a separate attempt at consolidating the payment data by project or activity, after the fieldwork was concluded.

The overriding conclusion is that monitoring is the weakest part of the programme. Although monitoring is carried out by UNICEF staff the monitoring set-up is a patchwork quilt of isolated, elements ranging from minute quantitative targets in some 20 projects and intervention areas to annual donor review meetings and everything in between:

a) the indicators are mostly irrelevant to an understanding of progress and achievements (or otherwise) and most have no targets;
b) the absence of qualitative indicators means that some of the programme's most important achievements go unnoticed
c) the absence of appropriate results indicators means that it is difficult to establish a relationship between what has been done and the programme's objectives/goal/purpose[19].

A budget of USD 245 000 was established in the Project Proposal for Monitoring and Evaluation, of which USD 115 000 was for monitoring up to the end of 2007: $35,000 for

[19] UNICEF's Evaluation Office and Division of Policy Planning has produced a useful guide that could be of assistance in establishing a coherent system "Understanding Results Based Programme Planning and Management – Tools to Reinforce Good Programme Planning", September 2003

"post campaign assessments" which remains virtually intact and $80,000 for a household health survey. To date neither of these has taken place and only USD 8 300 has been spent (on the current mid-term review and some other minor items). The funds could be usefully applied to some in-house monitoring initiatives. So far no more funds have been committed up to the end of 2008, giving an unused balance of USD 236 000. Clearly this allocation needs to be reviewed and proper funds set aside for monitoring in 2008.

The programme nature of the support makes it difficult to assess the contribution of the IRHA programme's contribution to either the various global objectives in Angola or its contribution to the UNICEF effort in this field. However, it should be noted that this situation has an important and positive aspect: collaboration for a common goal through more or less pooled funding. And although the $7.7 million is a relatively small amount compared to the almost $88 million provided by the Global Fund and the World Bank. The IHRA programme has made in particular two important and potentially lasting contributions - but very different in scale and approach - to the fight against AIDS in Angola. At one extreme there are the mass HIV/AIDS publicity and education campaigns and on the other hand discrete experimentation, piloting and lobbying for a more appropriate, effective and efficient clinical approach to a horizontally integrated HIV/AIDS, PMTCT, ARV, VCT and primary health care system.

A useful comment to the draft report by the SIDA regional AIDS adviser drew attention to the lack of clarity as to the requirement of a programme LFA and performance measurement linked budget, and the need for specific results based on the specific Norwegian-Swedish funding as opposed to overall programme results. The agreement document itself could have been more precise in this respect, and in the process make clearer what would constitute the basis of, for example, a mid-term review. While the TOR refer to "outcomes" the programme summary only identifies the goal, objectives and indicators, there is no reference to outcomes. The inclusion of a simple list of indicators is suggestive of a matrix approach to reporting of the kind adopted by UNICEF.

Although a coherent monitoring system based on an LFA structure and linked to budgets and accounts is not in place, the UNICEF staff pay regular monitoring visits to individual projects and partners. Unfortunately the results and observations from these monitoring visits are not fed into an overall system.

Monitoring Partners' Projects

Projects presented by potential partners are often reworked with them. In the case of new partners there is a "programme assessment" and a "financial assessment" covering the financial soundness of both the proposal and the organisation. Proposals are approved by a Contract Review Committee.

The contract signed with each partner has the following requirements[20]:

- the identification of one person authorized to supervise the project (project manager);
- the preparation of detailed annual work plans by quarter,
- UNICEF-partner consultation meetings at least once every three months and more if required;
- the partner can only alter the amount budgeted for a single budget line by 10% of the agreed amount and as long as the proposed modifications are in accordance with the

[20] Based on a sample contract and the assumption that it reflects a standard framework for all projects.

project proposal and its anticipated results, and it does not exceed the total budgeted amount. All changes above 10% require the prior and written consent of UNICEF;
- The partner must provide quarterly progress reports containing an evaluation of its performance and impact for children and women, and an assessment of whether the project is being implemented in accordance with the project proposal and budget, and the description of obstacles to full and timely implementation.
- A final report on the project results, including a financial report, will he submitted to UNICEF three months after the end of the Project.

The team had the opportunity to study all the project documents. The quality varied, although all used the same standard format for the budget. But while most projects have quantitative indicators (albeit not always very elucidating ones) some do not.[21].

In addition to verifying progress through these reports the relevant project officers make regular field visits to check up on progress and any difficulties that may have arisen.

3.1.8 Field Implementation and Operations

This budget line is included in the Project Proposal to pay for the incremental project support activities carried out by UNICEF and others to execute the Programme. The Project Proposal is referred to in the Agreements with Norway and Sweden, and therefore forms part of these agreements.

According to the UNICEF detailed expenditure statements the budget covers at least the partial or full payments of the following salaries:

- 14 drivers
- 10 administrative staff
- 3 project assistants
- 5 unspecified staff
- office equipment and supplies
- rent of warehouse,
- installation of LAN/cabling of office.

In addition to this, the project staff assigned full-time to a project are paid by the respective project budget, e.g. the salary of the UNICEF project coordinator for the HIV prevention through Schools and Communities is totally financed by this budget line.

The agreements with Sweden and Norway contain the following stipulations regarding Field Implementation and Operations and the Recovery Charge, the overhead charged and retained by UNICEF headquarters in New York:

- The Agreement with Sweden states that a 12% recovery charge can be debited in accordance with the UNICEF Board Decision 2003/9 of June 5, 2003. No allocation for Field Support is specified.

- The agreement with Norway refers to the Framework Agreement between Norway and UNICEF signed on 12 December 2003, and the Programme Proposal, received on October 25, 2005.

[21] E.g DPS Cunene,

> Clause 3.2 of the Programme Agreement with Norway states that seven per cent (7%) of the grant may be used for Incremental Field Office Administrative and Programme Support Costs, which are included in the Grant. There is no mentioning of recovery costs.

Although the Norwegian Agreement does not refer to Recovery Costs and the Swedish has no reference to Field Office Administrative and Programme Support Costs, both agreements refer to the Project Proposal which contains the programme budget. This budget has a line for Field Office Administrative and Programme Support Costs and one for Recovery Costs, and it is understood that the budget forms part of the agreements and is therefore the basis for expenditure by budget lines/sub-components.

Total expenditure for the Field Office Administrative and Programme Support component including the amount budgeted for 2008 amounts to USD 778 000, or 10% of total costs (assuming that the full budget will be used by end 2008). In addition there is a charge of USD 502 000 for recovery costs (7%). Budgeted recovery costs seem to be based on a contribution of 7% from Norway and 12% from Sweden, giving a budgeted total of 10%.

Our interpretation of the agreements is that the initial budget forms the basis for the allocation of funds for Field Office Administrative and Programme Support Costs and Recovery Costs, and this has resulted in overspending of USD 133 000 on the former and USD 265 000 less than the amount budgeted for Recovery Costs. In this connection it should be noted that Recovery Costs have been reduced by UNICEF from the initial 12% to a current 7%. No allocation for Recovery Costs has been made for 2008. It should also be noted that the budget gives Recovery Costs as a fixed 9.9% of annual costs. Clearly UNICEF and the donors need to sit down and thrash out the agreements and costs related to these two item as well as some others (see below).

3.1.9 Alterations

In terms of alterations to the agreed budget, point 3.4 of the agreement with Sweden states as follows: *"Any funds not fully utilized for one activity, may, upon written agreement between the Parties, be utilized for the benefit of other activities within the Programme"*. *"Deviations from agreed plans shall be informed to Sweden. Sweden may withhold disbursements if major deviations from agreed plans and budgets occur"*. The Agreement with Norway states in point 5.5: "*MFA may at any time withhold disbursements if major deviations from agreed plans and budgets occur. "*.

The budgets for various programme components have changed considerably:

- Policy development: underspending of USD 244 000 (33% of budget)
- HIV in schools: overspending of USD 929 000 (33%)
- Orphans: 0 used of the USD 20 000 planned
- Clinical Outreach: underspending of USD 861 000 (34%)
- Monitoring and evaluation: underspending of USD 236 000 (96%).

The figures above show the Programme Document budget as compared to actual expenditures so far. According to comments to the Draft Report by the Norwegian Embassy, expenditures in a year should be compared to the Annual Work Plan (which, as stated above, mainly is a budget). We have therefore attempted to do so (see explanation in section 3.1.7) as shown in the table below. We have also included the Programme Budget for 2007 in order that budget development also can be studied.

Table 6. Comparison of Budget and Actual Expenditure

Activity	2006		2007		
	Work plan	Used	Programme	Work plan	Used
01-03 Institutional support …	315 000	89 000	290 000	261 000	208 000
04-06 HIV prevention through school, etc	1 260 000	1 560 000	780 000	1 856 000	1 060 000
07 Orphans	20 000	0	0	0	0
08-11 Clinical outreach	1 190 000	600 000	640 000	1 183 000	947 000
12 -14 Monitoring	115 000	1 000	0	n.a.	1 000
15 Field implementation	293 000	208 000	183 000	n.a.	339 000

As seen from the table there have been substantial changes in budget from the initial Programme to the Annual Work Plan for 2007, and there are substantial deviations between the Annual Work Plan and actual expenditures both in 2006 and 2007. We have seen no document where these changes have been explicitly explained. Thus, we still think that UNICEF needs to clarify with donors whether this is acceptable. In perspective, UNICEF only allows 10% alterations in partner costs without its prior written consent.

3.1.10 On Outcomes and Sustainability

The TOR refer to recommendations on the effectiveness of the project, planned outcomes and "sustainability of the programme, especially with regard to cooperation with and capacity strengthening of relevant Angolan institutions". These aspects are related directly to some of the issues raised above. Of particular relevance are a) the weak monitoring, b) the nature of the IHRA programme and its relationship to the larger UNICEF country programme and c) the nature of some of the main activities undertaken:

- The very limited and incomplete Logframe in the "Agreed Programme Summary" has no outcome (OECD definition: "the likely short-term effects of an intervention's outputs" or "the effects that can be directly attributed to an intervention ….or its effects on the target group……")
- The reporting matrix contains only limited and scattered data and very little hard quantitative data on what has been achieved t o date and thus what can be expected;
- As many projects are ongoing and/or pilot activities it is not possible to identify effects or outcomes even if they were to be defined;
- Some of the biggest (financially) activities have intangible effects of the "awareness raising" kind that are very difficult to assess (school and youth programmes, life skills, OVC pediatric AIDS support etc.);
- Many of the full effects will be the result of the UNICEF Angola programme as a whole as well as contributions from other important donor projects e.g. the World Bank HAMSET project.
- Many activities are of a pilot and thus experimental nature.

For this reason most conclusions can only have a "potential" element.

The most that can be said at the moment is merely to present some examples of the components/projects most likely to provide data on concrete outcomes (for obvious reasons, mainly the "nuts and bolts" clinical and outreach projects):

- As more people have gone for voluntary testing (particularly pregnant women and their immediate family members, youth) more HIV+ people have been identified and simultaneously have ready access to ARVT, the survival and quality of life prospects of PLWA in the areas covered have improved;
- The ADPP project should be one of the country's only sources of concrete data on HIV/AIDS incidence in the municipalities covered;
- As more young people are aware of and are correctly informed about the nature of AIDS, as PWLA are finally able to demonstrate their quality of life prospects while at the same time debunking prejudice, it can be assumed that (but not demonstrated) that more people (youth in particular) will take appropriate precautionary measures in their sexual activity and hopefully will be more tolerant and positive towards identified PLWA;
- The quality of life of families benefiting from programme, of families with children receiving support under the pediatric AIDS counseling programmes may have improved.

As regards sustainability in terms of government capacity there is clearly scope for support at both central and government level and in some instances. The health sector appears to be well covered by ongoing programmes but the work done with the Ministries of Education, and Youth and Sports, showed their important role in the HIV/AIDS education, awareness raising, fighting prejudice etc. Given the decentralization process, capacity building at provincial and lower levels is also important and in some instances may find a more receptive environment. UNICEF has been able to place an official representative in the Governor's office in Cunene and the Governor expressed to the Review Team his interest in receiving additional inputs.

3.2 Financial Management

UNICEF's Financial Management has strict guidelines. All expenditure in the field and by partners needs to be documented by original receipts that are controlled by the UNICEF office in Angola. An Interoffice Memorandum of December 14, 2007 lays down the procedures that entail a clear division of authority between the following:

- Authorising Officer who ensures that the inputs are necessary and funds are available (and a number of other requirements),
- Obligating Officer who, following authorization, will generate a legal obligation such as a purchase order, travel authorization, etc.
- Certifying Officer who ensures that the services and goods delivered agree exactly with the quantity and quality specified, that they have been rendered, etc,
- Approving Officer who ensures that the transaction agrees with the original authorization, etc
- Paying Officer, who ensures that the documentation is complete and the payment request is correct.

The division of responsibility between the officers is designed in such a way that, for instance, the Authorising Officer/Approving Officer for a specific transaction etc. is not the same as the Certifying Officer. Each Officer is allocated limits for their signing authority, and the Programme Management System used to handle all transactions ensures that these limits are not exceeded. Such a system gives credibility as to proper management of the funds received.

The financial management of the approved projects is carried out in the country office of UNICEF Angola and is supported by a detailed Financial Management Questionnaire that is filled in by the respective UNICEF Project Officer. The questionnaire gives a risk assessment of the Implementing Partner, the entity's Fund Flows, Staffing, Accounting Policies and Procedures, Internal Audit, Reporting and Monitoring and Information System. In addition the Project Officers carry out verification that spending and accounting are in accordance with the activities specified in the project document. This is clearly the most important responsibility in terms of ensuring that funds are used as agreed. In addition it is crucial that expenditure items are allocated to the relevant budget item in order that the cost of an actual activity can be directly compared to planned.

Only up to 5% of the overall project budget can be reallocated by the partners without UNICEF's approval.

Project accounting is carried out in the UNICEF Angola office, which feeds into the global UNICEF accounting in New York where accounts are finalised and audited. Funds are allocated from the UNICEF NYHQ to the country office based on annual work plans. Budgets and spending by programme, project and sub-activity were produced quickly upon request.

In the financial reports it is important to distinguish between Requisition Amount and Actual Spent Amount. In the "Norway-Sweden Joint HIV Project Monitoring Sheet – Summary" (see Annex 3) item 01 – "*Technical Support for Policy, Procedures, Planning and Guidelines*" - has a total budget of USD 335 000 for the three-year period. , "As of 31/12 08" the amount used was USD 437 720. This amount was received from the HQ ("Requisition Amount"), but at the end of 2007 only USD 265 018 had been spent. Thus, in order to reach USD 437 720 an additional USD 172 702 need to be spent in 2008.

4 CONCLUSIONS AND RECOMMENDATIONS

The Angolan context is special in at least three respects:

- The comparably low prevalence of HIV/AIDS (4-5%) compared to much higher rates in neighbouring countries,
- The comparably high – and increasing rapidly - GDP per capita of USD 4-5000, and government spending on health and education that is much higher than other African countries.
- The absence of reliable baseline population data and subsequently, consequently for all human development indices measures, including HIV/AIDS prevalence, etc.

4.1 Conclusions

a) The programme as a whole has made a significant contribution to fighting HIv/AIDS in Angola. It successfully matches the country's needs as presented in the government's Strategic Plan with UNICEF's mandate, in particular through its decision to focus on youth-oriented prevention.

b) Achievement of Objectives. On the whole the programme appears to have made a positive contribution to some of the various objectives that could be attributed to it (of the programme itself, the Government's Strategic Plan, the UNICEF Country Programme):

- "Enhance institutional capacity to ensure rapid, multi-sectoral and decentralised responses" : yes, in particular through its support for the local health authority in Cunene, the province with the most serious AIDS problem in the country. In addition the different kinds of technical and advocacy inputs to protocols, guidelines, testing more appropriate forms of service delivery, its work with the Ministries of Education and of Youth and Sports on mass campaigns and school based programmes as well as its support for the communication strategy have all contributed to strengthening Angolan institutions in various ways;

  As regards "Reducing the incidence of HIV/AIDS": yes, there is a strong probability of impact in Cunene provinces through the concentration of mutually reinforcing projects in particular DPS capacity building + clinical outreach aimed at more effective and efficient service provision + high intensity grass roots mobilisation. Potentially also yes on much larger scale if the in- and out-of-school youth campaigns succeeded not only in being heard, which they most certainly were, but in being retained and acted upon by government and civil society . This requires constant and consistent repetition and follow-up than is possible under this particular programme, but will hopefully be pursued by other current and future programmes.

- "Mitigating the impact of HIV/AIDS on individuals, families and communities" : Not specifically as the Review Team has strong reservations about the single pilot initiative under this heading. However, other aspects of the programme such as the

the clinical and outreach component and paediatric AIDS support must also have helped.

- Improved survival, safety, health, social acceptance of HIV-AIDS affected: As regards "survival, safety and health" probably good impact in the provinces where the programme has a geographical focus with mutually reinforcing components, as in the case of Cunene..

  "Social acceptance" "Social acceptance" is more complex as it requires a long slow haul rather than a quick fix. The Nevertheless, the programme provided strong "kick-off" support with its youth-directed saturation campaigns and this is being complemented by its support for more systematic awareness raising of the grass roots type through life skills clubs with church groups and a start has been made on promoting PLWA.

- Survival, safety, health, social acceptance ……"with a particular focus on girls and women" No. A serious omission of the programme is its inability to promote activities that specifically target women and girls. PMTCT is not a gender based approach but a medical solution to the birth of HIV+ babies. The team had the opportunity to observe the active and equal participation of girls in a life skills programme run by a protestant church. However, it seems that on the whole boys were in a better position to take advantage of out-of-school programmes than girls. Many activities had inherent gender aspects but this is not the same as the kind of pro-active initiatives to be expected when the goal specifically states "a **particular focus** on girls and young women". This is highlighted by that fact that only one key result is really gender-based (sensitization of women leaders and market vendors") and this activity was dropped. Moreover, its two indicators were the only ones out of 39 indicators that had specific gender targets.

  The review team did not have the opportunity to study sexuality issues and homosexuality, other than to note the apparent cultural tolerance of sexual relations between young women and much older men. Interestingly, in the many meetings on AIDS issues no informant spontaneously referred to homosexuality as an issue or cause.

The overall conclusion on achievements is that the programme has made a useful contribution to addressing the AIDS problem in Angola. Activities at two ends of the spectrum warrant special mention as indicative of the UNICEF approach. On the one hand, the two mass campaigns that by all accounts had an impact out of all proportion to the size of the programme. On the other hand there is the slow, painstaking pilot and advocacy work using clinical outreach projects to promote more effective and efficient service delivery.

It should also be noted that these important conclusion are based mainly on impressionistic evidence and subjective reports. There was only one instance where an independent evaluation was commissioned – the in-school campaign, and most of this was not funded by the programme.

c) The programme has not always adhered to the initial composition as presented and agreed in the programme proposal document. This in itself is not necessarily a negative feature. The

need for flexibility is the necessary corollary of the many, often unpredictable factors inherent to the complex HIV/AIDS context: the programme's broad scope, itself a reflection of this complexity, the presence of other agencies, the number of government institutions with strong engagement (health, education, social welfare, labour), the sometimes unpredictable nature of government interventions (or lack thereof), civil society….

However, what is a problem is the insufficient documentation and justification for changes, including the non-performance of planned programmes.

d) The programme's weakest points are its monitoring and reporting shortcomings that have already been discussed in some detail. Each of the 20 or so projects/activities had indicators and regular (quarterly) narrative reporting obligations. The programme document referred to a list of monitoring tools that would be used (reports, sentinel sites, youth KAPB surveys and "project monitoring") but without any indication as to which would be used where and for what purpose. The IHRA programme document contains a list of around 40 mainly quantitative indicators, with no targets and no appropriate means of verification other than "project monitoring". The annual report to donors is a matrix based solely on these indicators where IHRA outputs are mixed with non-programme figures and there is no narrative text analysing the results or placing them in the right context.

e) Financial Reporting also presents some problems for programme monitoring. UNICEF as an organisation has a rigorous and standard financial management system. In addition to presenting income and expenditure in a manner required by international accounting practices it can also produce a list of all expenditure items under the more than 20 components and subcomponent budget lines. Although some items occasionally appear under what appears to be the wrong heading there can be various reasons. It is the relevant programme officer who decides the budget line to which a given expenditure item should be attributed, and this may be due to error, the apparent fungibility of some items (especially between the lines of a single component), or merely the fact that one budget line has more funds available.

However, such instances run the risk of undermining the financial and management system and should be held in check.

A more immediate problem for the programme monitoring function is that the detailed statements produced by the financial system have a level of disaggregation that stops at the budget line. In other words, there is no system for grouping related items for a project, or for a campaign. This is not so much a financial accounting issue as a management one, and made it virtually impossible for the review team to compare what funds were spent on what in the original programme plan. However, one example has already been given – relatively little of the roughly $ 470,000 spent on the "Policy Development and Institutional Capacity Building" component was of the kind envisaged in the programme proposal. Without a structure that permits matching (financial) inputs with (project) outputs it is not possible to draw any conclusions about efficiency.

The most difficult exercise carried out during the review was to try and achieve such a rough match for 2006, but there was insufficient time to undertake a more thorough exercise for the whole programme. Some examples are however given in Annex 5.

f) Sustainability per se is not a major issue for the programme as many of the activities are considered to be of a pilot nature. Moreover, based on the substantial increase in government

health budget GOA should be able to take over whatever is found to be successful e.g. innovations in health centres and outreach services. However, this is not so in the case of major campaigns, where there are signs that when completely taken over by GOA/Ministry of Youth and Sport the scale of the programmes is considerably reduced. Moreover, funds are not the only answer – the human resource component is vital – be it the health official who has to be convinced of better methods, the disinterested civil servant or the overworked school teacher, all of whom can determine whether an initiative succeeds or fails.

There is clearly scope for more work with government authorities at central and local level – as regards youth and AIDS education in the Ministries of Education and Youth and Sport in particular.

While it is probable that faith-based groups will be able to continue the youth groups and life skills activities started under IRHA the NGOs may find it more difficult as they tend to have limited alternative resources. Moreover, it seems that the eventual success of at least two projects - ADPP "Total Control" and ADRA "Impact Mitigation", both in Cunene, requires that they run for the intended three years rather than the two years funded by the AHRA/UNICEF programme. It seems rather short sighted to take on a couple of projects with a total budget of over $1 million without any prospect of their being brought to fruition for the full period. It is to be hoped that there is a back-up plan somewhere.

This raises the related issue of the role of UNICEF in projects in general and AIDS projects in particular that require at least a medium-term time frame, when the organisation cannot enter into commitments for more than two years. The result is visible, for example, in the piecemeal support for Caritas life skills centres: 12 months, then 9 months, then 3 months, then 11 months.

g) The programme is somewhat different to the initial composition as presented and agreed in the programme proposal document. This in itself is not necessarily a negative feature. The need for flexibility is the necessary corollary of the many, often unpredictable factors inherent to the complex context and the programme's scope. However, what is a problem is the insufficient documentation and justification for changes, including the non-performance of planned programmes. Donors and UNICEF need to reconcile agreements, Annual Work Plans/budgets, spending and reporting in order to establish whether actual execution and reporting meet agreed targets, and whether field implementation costs, recovery costs and budget deviations are within agreed levels.

h) Finally, the Review Team would like to note that much of what has been achieved under the programme is due the dedicated and hardworking UNICEF staff and the organisation's good working relationship with its partners: donors, other UN agencies, government and NGOs.

4.2 Lessons Learned

a) For proper project management, monitoring and evaluation of a programme of this size and complexity a clear and manageable project document is fundamental. Such a project must be based on a clear description of the baseline and a strong LFA programme structure whereby achievements can be measured and costs allocated. For example, the source of verification

column in the indicators matrix was invariably “project monitoring” i.e. the source of verification for monitoring indicators was monitoring.

b) At the same time it is recognised that an agency such as UNICEF faces a complex management situation. It has many community-based or “local” activities that can be very management intensive and much of its funding is provided through by donors, each with its own project content, management and reporting requirements. These requirements should try to strike a balance between providing sufficient information to enable the donor (and any review team) to assess the application and effectiveness of the funds but without making UNICEF’s management and monitoring too onerous.

c) A related issue is the need to allow for considerable flexibility. UNICEF has a country programme and plan that has to reflect both its mandate and the reality of the country in which it is working. The team was informed that the preparation of the IRHA programme also took into account projects in the pipeline awaiting funding, ongoing projects that needed to continue, firm plans for major activities such as the campaigns and consultations with government and other entities. Some of the planned activities did not take place because the proponents lost interest e.g. the proposal involving the sensitisation vendors and influential women on gender, self-esteem and HIV/AIDS issues. The study on orphans and children did not take place because it was funded by DFID. Instead, the IRHA programme financed very relevant and useful follow-up work in Cunene province. However, the agreement needs to define clearly the degree of latitude and the point at which the donor needs to be consulted and/or provide authorisation for major changes in the agreed programme.

d) The monitoring system in such a complex context has to be able to address two levels:first, the individual projects that comprise the programme and second, the impact of the programme as a whole on the problem to be addressed, in this case the HIV/AIDS epidemic. How did the programme as a whole perform? One way of addressing this problem would be to combine the random selection of individual projects for in-depth monitoring (in particular projects of a pilot nature) with a more general evaluation of the overall performance of the programme. This requires two sets of indicators – for the projects and for the programme.

e) Indicators need targets and targets need a baseline against which progress is to be measured. In cases such as Angola where there is no real reliable baseline information, the best “guesstimate” should be identified, or at least some kind of initial point of reference against which the performance of a project or programme can be judged.

f) The “Letters of exchange agreement between the Norwegian Ministry of Foreign Affairs and the United Nations Children’s Fund in Angola regarding Inter-sectoral response to HIV/AIDS in Angola” appears to reflect the kind of standard or model letter for Norwegian support to UNICEF country programmes. The Angola experience suggests that these should be capable of adaptation to the reality of countries with special circumstances such as the Angola case (through a special addendum if necessary).

g) UNICEF has a standard international accounting system that produces the kind of information required for a standard financial audit. The monitoring and in particular the evaluation of a multi-project programme requires an information system that shows the expenditure on each project or activity area. The financial statements for the IRHA programme are divided into the four programme components with a total of 14 budget lines with roughly 220 expenditure (plus one budget line for “Field Implementation and Operations

containing roughly 60 items, about 12% of the total). Rapid monitoring of progress and expenditure would be greatly facilitated if these expenditure items could be subsequently grouped by project or activity area – a task that should not require a great deal of effort and need not necessarily be done by the finance department. It would provide both the donor and UNICEF with a clearer picture of where and how resources are being applied.

4.3 Recommendations

As there is less than one year left no major reorientation of the programme is possible or recommended. However:

a) Based on existing agreements UNICEF should clarify with donors major ~~deviations~~ alterations and issues related to the cost level of Field Implementation and Operations and Recovery Costs, and the structure of remaining reporting.

b) Given the important role of pilot activities and learning UNICEF should revise its M&E system to make it more appropriate to assessing the programme's stated results. It should also take into account the kind of information that will be required for a final objective evaluation of the programme, including its effectiveness and cost efficiency. In this respect the financial reporting system should be revised in order to facilitate better monitoring and reporting of expenditure by project and component.

c) Given the importance of information in monitoring the current programme and in order to support the development of the government's monitoring capacity as much assistance as possible should be provided to help the government (INLS in particular) to develop databases that help it to overcome its major information deficit.

d) UNICEF should focus on activities that assist the government in terms of protocols and procedures that reduce the stigma of HIV/AIDS and promote its prevention and treatment in clinics as "one of many illnesses". The ADDP and ADRA projects should also be carefully looked into in this respect to assess whether they contribute to the stigma or not.

e) Preparations for any future contribution to the UNICEF programme should identify in advance the extent to which the programme being supported is an integrated part of the global UNICEF programme and the extent to which it has its own self-contained "identity" that can be assessed or evaluated independently. If it cannot be given autonomous characteristics that permit an autonomous assessment of aspects such as effectiveness and cost efficiency then it should be accepted that these and related aspects will be the result of a (multi-donor?) mid-term and final review of the <u>entire programme</u>.

In the event of the former option (a relatively autonomous programme) the agreement must be based on a proper and complete results-based Logframe programme document and monitoring system. In the event of awareness raising intangible outcomes public opinion surveys or "citizen report card" approaches should be considered.

A more autonomous programme could have more limited focus e.g. only youth directed

mobilization, institutional capacity building in specific government agencies/civil society organizations, in certain provincial institutions (e.g. an intensification of the Cunene focus including not only health and radio but also local education and youth authorities (see below).

g) With the exception of the Cunene provincial health service capacity building support has been the offshoot of programmes rather than a target in itself. This is not necessarily a bad thing as capacity building is often best done around a concrete activity or target. However, should a new programme have more of a capacity building focus it could address the potential established during the current programme e.g. the central and local structures of the Ministries of Education and Youth and Sport, using the BBC Trust that has already proved its competence in the campaign field. The INLS is also an obvious capacity building target, in particular its statistical data and planning capacity. A strong capacity building component should also include the relevant civil society organizations.

However, this recommendation has two possible impediments: the government's desire for/willingness to accept this kind of assistance and its fit with UNICEF's country programme.

ANNEX 1: TERMS OF REFERENCE

FINAL DRAFT PER 12.12.2007 External (" TOWARDS THE END") Review of the Norwegian / Swedish support to HIV/Aids through UNICEF

1. Background

UNICEF Angola has been active in HIV/AIDS efforts since 1999. The majority of UNICEF interventions have focused on prevention among youth, including 12 integrated youth centres, VCT, Youth Friendly Health Services (YFHS), and educational opportunities to those both within and outside the formal education system, plus creation of protection mechanisms for orphans. UNICEF and its partners have assisted the Government of Angola in elaborating a National HIV/AIDS Strategic Plan with youth-driven priorities (the communications strategy for prevention) as well as the elaboration of protocols for VCT and PMTCT.

The Norwegian Embassy entered into agreement with UNICEF on "Inter-sectoral response to HIV/AIDS in Angola" on 15 June 2006. The agreement runs from 2006 to 2008 and has a financial maximum value of NOK 20 mill. The Swedish Embassy entered into an agreement with UNICEF on the same program in December 2005. The Swedish grant totals SEK 35 mill.

The Goal of the 2006-2008 Programme is to improve the survival, safety, health, and social acceptance of children and youth directly or indirectly affected by HIV/AIDS, with a particular focus on girls and young women.
The Objectives of the Programme are to enhance institutional capacity to ensure rapid, multi-sectoral and decentralized responses to the epidemic; reduce the incidence of STIHIV/ AIDS; and to mitigate the impact of HIV/AIDS on individuals, families and communities.

Article 8 of the agreement states that " an independent mid-term review will be agreed upon by UNICEF, MFA and other donors. It is recommended that the review take a sector wide approach. The cost of the review will be covered by MFA with funds over and abovethe Grant."

An additional evaluation of the 2006-2008 inter-sectoral programme is not anticipated within this programme period. This review is expected to include information that is of relevance to UNICEF, would the organization plan to pursue HIV/AIDS work after 2008, and into the new Country Programme.

2. Main purpose of the review

The purpose of the review is to
- examine how the programme is implemented relative to the objectives set out,
- review the cooperation and coordination between UNICEF, UN Agencies and Government institutions, and other actors working with HIV/AIDS and the division of labour between these players.
- discuss findings with UNICEF and other partners involved in the programme

3. Scope of work

The work shall comprise, but not necessarily be limited to, the following questions:

• Assess and provide recommendations on the effectiveness of the project: activities and output related to objectives, indicators and plans.
• Assess the progress of the programme and to what extent the planned outcomes can be reached by 2008
• Assess and provide recommendations on the sustainability of the programme especially with regard to cooperation with, and capacity strengthening of, relevant Angolan institutions.
• Assess and provide recommendations on the efficiency of the project; comment on the cost-effectiveness and whether resources have been used in an efficient way.
• Assess and provide recommendations on to what extent Norwegian policy on gender based discrimination, sexuality (including homosexuality), prevention, and the need to bring greater openness to these areas are being pursued in Angola.

4. Mid-Term Review Team

A review team of three (one international and two regional/national) consultants shall be identified'. The international consultant will be team leader and responsible for writing the final report.

At least two team-members must be fluent in Portuguese and English. At least one of the team members shall be a woman. The team composition must also include
• Documented knowledge and experience on HIV/AIDS epidemic from the sub-Saharan region, while such experience from Angola is added-value
• Knowledge of the drivers of the epidemic (developmental, social and biological)
• Knowledge in both quantitative and qualitative evaluation methods
• Must have experience from evaluation assignments in the sub-Saharan Region
• Experience on various key-stakeholders in the epidemic (Multi-laterals, donors, NGOs)

The review team will be expected to develop a "proposed technical approach" to the review. The technical approach shall be limited to 5 pages and contain

1. Summary of profiles of the consultants or the consultancy firm
2. A response to how the Scope of work is understood
3. A detailed work plan
4. List of stakeholders to interview
5. Methods for the review

1 The team can also consist of only two members, one international and one national, if this is found more
appropriate for the task.

5. Methods

The review Team will be given access to all documentation relevant to the study (programme and project document, contracts, reports, financial statements, audits etc) at both the Norwegian and the Swedish Embassy and at UNICEF Angola. The team should also familiarise itself with relevant MFA and UNICEF strategy documents. As most

means of verification in the M&E framework is project monitoring, these reports shall be obtained from UNICEF Angola by the embassy prior to the review.
The review shall preferably use a mixture of quantitative and qualitative methods (triangulation). One or two case studies are regarded as an added value to the final report. The Norwegian Embassy shall make national statistics, such as data from ANC available to the team.
The team shall debrief UNICEF and the Norwegian and the Swedish Embassies in addition to other relevant donors on the main findings and conclusions of the report, at the end of their field work in Luanda. A draft report shall be submitted no later than two weeks after return. The parties should be given one week to comment. The final report shall be ready by 15th March 2008.

6. Consultancy days
The Review Team will be given 4 days for preparatory work, 15 days of field work in Angola, and 15 days for the writing of the final report. Estimated time for the review will be one and a half month, with planned start up beginning of February, to be decided between MFA Angola, Norad and the consultant.

7. Reporting
The report shall be analytical in content and consist of an Executive Summary, Methodology used; Major findings and assessments, Lessons Learnt, Conclusions and Concrete Recommendations for improvement.
The report shall be in English, include a short summary and shall not exceed 30 pages (excluding annexes). Annexes must include the ToR, the technical response with workplan, people/organisations consulted, questionnaires and any other information as considered relevant by the consultants.
The final draft of the report, consisting of 2 bounded copies, 2 copies submitted/sent by e-mail in the formats of doc and pdf

8. Logistics
UNICEF will provide the necessary logistics for meetings and field visits, including office space.

ANNEX 2: BACKGROUND

Covering 25 million km^2 or twice the size of France and with estimated population of some 16 million inhabitants[22] Angola is one of the most sparsely populated countries in the world, in its rural areas. Thirty years of war intensified conventional rural-urban migration patters and today an estimated 50% of the country's population lives in urban areas, one third in and around the capital Luanda. Almost 80% of them are very poor (living on less than $2/day) and 26% are destitute (living on less than USD1 a day).

The administrative division of Angola comprises 18 provinces, 163 municipalities[23] further subdivided into 532 communes. These are probably virtually the only reliable figures in the country where a population census is long overdue, government data systems have yet to recover from their war-time collapse, and the impact of the war on demographics is unknown. This means that virtually every figure – from GDP per capita to the prevalence of HIV/AIDS – is invariably an estimate based on an estimate and there are few baseline figures against development targets can be measured.

Despite immense resources, oil, gas, diamonds, other minerals, hydropower, timber, fisheries and plentiful arable land Angola has a collection of development indicators that put it among the poorest countries in the world. Despite a GDP per capita of around $4,000 (2007) it is ranked 166th among the 177 countries in the United Nations Development Index. It has some of the worst (in some instances the worst) indicator ratings in the world. Its infant mortality rate is one of the highest in the world (a quarter of all children die before they are five years old), life expectancy at birth is 40 (the 10th lowest) and it has the highest fertility rate of 7 children per woman.

GDP is expected to nearly double between 2007 and 2012. External debt are falling and inflation was in 2007 10%. The strong economic development has allowed for substantial increases in the Government health and education budgets, education rising from USD 784m in 2005 to USD 2 720m in 2008, and health from 5.8% of budget in 2007 to 6.68 % in 2008. As well as significant increases in budget allocations, the budget execution has also had a tremendous increase, from 66% in 2005 to 85% in 2007.

The main reason for this paradox is some 27 years of civil conflict (1975-2002) between the MPLA government and the opposing UNITA. A brief period of peace with general elections collapsed when the results were not accepted by the UNITA President. The war was resumed and lasted until his death and the signing of the Luena peace agreement in April 2002. Despite the hostilities the elected deputies remained in the capital and participated in the work of the National Assembly. The absence of further elections means that it has functioned with its current composition for 16 years. New elections will be held later this year following a voter registration process that recorded about 8 million people (which could imply that the total population is considerably higher than the estimated 14 million).

Nevertheless, democracy is this still somewhat fragile. And although civil society is expanding and getting stronger it still faces serious operational limitations. The Norway-Denmark inter-sectoral AIDS Response Programme (NDIRP) found that potential candidates for funding had very weak project preparation and implementation capacity.

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[22] given the absence of sound records during 30 years of war, most figures on Angola, its population and their wellbeing, their access to social services are little more than guesstimates. According to the National Statistics Institute the population rose from 5.6 million in 1970 to 13.8 million in 2001.

[23] The *municipio* is the subdivision of a province, not an urban area as understood by the English "municipality".

The 2002 peace agreement was followed by a major national reconstruction programme – covering both physical infrastructure (including the total reconstruction of some towns, such as Ondjiwa in the Cunene province – which was visited by the Review Team) and services, in particular health, education and social welfare services that had collapsed during the many years of war.

Despite the growth in oil output the financial demands of the war resulted in a substantial foreign debt, which has fallen from 60% of GDP in 2003 to 39% in 2007. Inflation is down from 102% in 2002 to currently 10% per annum. However the peace bonus of recovering agriculture and manufacturing coupled with the effect of economic reforms was heightened by new producing wells, government control over the diamond industry and soon afterwards windfall profits from the rising oil price[24]. The impact can be seen in the budget figures that doubled between 2005 and 2007, when it reached US$ 23 billion. The 2008 budget is up 31% from 2007 and is equivalent to as much as US$ 2 000 per inhabitant. This enables the reconstruction process to gather momentum (not just road and rail communications but also government administrative and social infrastructure that facilitated the reintegration of previously isolated areas).

Post-war developments have included a 2007 law introducing a gradual process of decentralisation, deconcentration and transfer of resources to sub-national governments. Their organisational structure will include collegiate and singular organisations including, at municipal level, a Provincial Council for Hearings and Social Conciliation. Although there are still many aspects to be worked out, including as yet un-clarified distribution of social and educational powers between the provincial and municipal levels. Nevertheless, no matter what the outcome it could be highly relevant to the pursuance of a dynamic HIV/AIDS programme (or not as the case may be).

Since 2002 the combination of peace, higher oil production and prices, revenue from diamond production, some economic reform measures and heavy investment in the reconstruction of the country (starting with road and rail communications and the provision of basic premises to house government services in order to reintegrate previously isolated areas) have resulted in a strong, more broad-based economic recovery that includes the non-oil economy. As some people move back to their home areas agricultural output is increasing.

Between 2005 and 2007 in particular, the country experienced major transformations. This is nowhere more apparent than in the budget, which doubled during this period. Budgets for education and health rose roughly 2.5 times, and the social welfare allocations even more so[25]. In 2007 education accounted for 5.6% of the budget, health 3.7% (6.7% in 2008) and social and welfare 10.6%. Even though this represents slippage compared to the previous year, in absolute terms expenditure it is still considerably higher than in many other countries: in 2005 per capita expenditure on health was US$29 compared to US$ 14 in Zimbabwe. In the approved budget for 2008 health expenditures amount to as much USD 164 per capita.

Data problems aside, it is clear that the efficiency and effectiveness of public services still leave a great deal to be desired. This is hardly surprising given progress in this field requires not just physical infrastructure but the appropriately trained manpower and also the updating of policies, guidelines, curricula etc. These take a long time to come to fruition, and the

[24] Between 2001 and 2005 oil production rose from 741,000 to 1,200 000 barrels a day and the oil price from $22.7 a barrel to $39 (++), and in 2008 for a brief period reached $100

[25] The Ministry of Social Welfare is much stronger and its mandate much broader than its counterparts elsewhere.

processes are much more complex and protracted than the construction of a school or health post.

Nevertheless there are reasons for concern, not least the fact that budget execution data indicate that in both the education and the health sector delivery of the primary level services vital for reducing poverty might not have top priority.

In conclusion, given Angola's enormous domestic resources it does not require substantial financial assistance from donors. What it does need, however, is technical assistance in a variety of sectors and roles so that its financial and human resources are made as productive as possible.

Cunene

The Review Team visited Cunene province during three days.

The Cunene province has an area of 77,000 km2 and an (estimated) population of 750,000 i.e. possibly 0.5 % of the country's population. Given that about 11% of the population is HIV positive, the affected population could be in the range of 80 000.

The province is divided into six municipalities and 20 communes. It has the highest prevalence of HIV/AIDS in the country. In 2007 the health service had 48 doctors (7 Angolans and 41 expatriates and 624 nurses, 53 of whom with middle level training) working in 4 hospitals, 6 health centres and 68 health posts.

According to the local health authorities as of May 2007 the province had the following HIV-AIDS clinical activities:

- 27,100 ATV consultations (of which roughly 14,400 PTV, 11,900 adults and 820 children)
- 19,700 tests (roughly 9750 PTV, 9180 adults and 550 children)
- HIV+ results 4054 (21%) 1216 pregnant women, 2717 adults and 164 children)

HIV-AIDS in Angola – a unique scenario

Despite strong reservations about the reliability of statistics due to low coverage (only a few surveillance centers), it is widely acknowledged that Angola has a much lower prevalence of HIV/AIDS, around 4-5 %, than its neighbours and indeed Africa as a whole. This is unusual given the country's history of war with large contingents of armed forces scattered around the country and the destruction of health services and facilities.

According to the 2007-2010 Strategic National Plan on AIDS:

- Between 1985 when the first case was recorded and November 2006 there were roughly 24,800 recorded cases, equivalent to 6.2 % of estimated infections in the country (roughly 400,000) and an infection prevalence of 2.5%.
- The number of cases recorded each year rose from 1,000 cases in 1997 to around 4,740 in 2005 and 4,800 in the first 11 months of 2006.
- 60% of cases since 1985 have occurred in people aged 20-39 and principally among women.
- The main source of transmission was heterosexual sex , followed by blood transfusions with 19%.
- Studies of sex workers in Luanda found a 20% prevalence in 1999, rising to 33% in 2001.
-

Studies in 26 sentinel sites in 2004 and 2005 found that the worst affected provinces were:

Table 1: Provinces most affected by HIV/AIDS

Provinces	2004 % population	2005 % population
Cunene	9.3%	10.6%
Huila	2.8%	4.2%
Lunda Norte	3.3	3.4
Lunda Sul	3.4	3.6
Namibe	2.0	3.7

In 2006 (a year after the nationwide AIDS in education campaign, see below) a KAP survey conducted by PSI among the 14-18 age group in 6 provinces found strong geographical and gender variations. Overall, 99% of those interviewed had heard about AIDS and 77% thought it was a serious problem, but while the level was 100% of the total in Luanda it was only 63% in Lunda Sul province.[26]

The survey also found that for many informants "hearing about AIDS" was the limit of their knowledge: some 90% did not know the three key methods for protection, in particular the uneducated group (36%) compared to the educated group (3%). About 21% knew that abstinence was a form of protection.

Various past and present features of the Angola situation provide fertile ground for the spread of the disease:

- Initially, during and immediately after the war troop movements and population displacement within the country and across its borders with neighboring countries with a high incidence of HIV/AIDS;
- rapid urbanization coupled with poverty, driving the sexual exploitation of women and children as sex workers;
- peace brought more traffic along road corridors expanding the threats presented by high risk candidates such as lorry drivers;
- inadequate coverage by the National Health System;
- cultural factors: a tradition of early sexual relations for the age of 15 onwards (45% of the PSI survey informants), the inferior status and power of girls and women, multiple partners relations between young girls and much older men (the PSI survey found that the average age of partners of a 24-year-old woman was 39);

In addition, even when there is knowledge of the danger of unprotected sex this is not followed through. According to the PSI survey almost 70% of informants practiced unprotected sex, 42% were unconcerned about getting infected and only 9% were aware their behaviour was high risk. The most vulnerable groups were those with little education, girls and the younger informants.

In terms of response strategy the figures send the following messages:

- The danger of underestimating the threat (not just GOA but also the population) and doing nothing. Angola is in a unique position to benefit from the experience of other countries and stem the spread of the disease through vigorous prevention measures;

[26] Interestingly one fifth of the informants said they knew someone who had AIDS – if true this points to stronger prevalence than anticipated.

- Average figures conceal important regional variations, with higher levels in provinces bordering high-incidence[27] (and within these provinces in the areas closest to borders) and among particular social groups. The incidence of HIV-AIDS in the southern province of Cunene, which shares a common border with Namibia, is estimated to be around 10% and among sex workers in Luanda about one third.
- The need to focus on prevention in particular.
- The need for urgent improvements in data collection in order to obtain a more reliable picture of the threat and how to tackle it.

In 2004 the main donor supported programmes in the HIV-AIDS field were the following.[28]

Table 2 donor supported programmes in HIV/AIDS

Project/Activity	Agency	USD
Epidemiological surveillance	WHO, UNICEF, Italy	534,000
Community participation	UNICEF	500,000
Communication risk groups	USAID	513,000
IEC in education system	Norway and UNDP	3,423,000
Transfusion safety	USA	2,379,000
HIV/AIDS control	Global Fund	27,600,000

By 2006 number and volume of programmes had risen considerably, through the addition of the Global Fund, Hamset and the Norway-Sweden contribution to UNICEF.

The major transformations between 2005 and the end of 2007 mentioned above were reflected in the AIDS scene:

- The country passed from the end of a war-to-peace transition and GOA was finally able to concentrate on development;
- The effects of the shift from war-time emergency mode not just to reconstruction but also policy and strategy formulation mode started to be felt;
- GOA was not constrained by a lack of financial resources, it had ample funds;
- Widespread reconstruction opened up access throughout the country and expanded the health network;
- All the above enabled the government to make a qualitative leap from passivity on HIV/AIDS to pro-active engagement not only on prevention but also on clinical support for PLWAs;
- In late 2005-early 2007 two major new players entered the AIDS field: the Global Fund administered by UNDP and the World Bank Hamset programme bringing not just funds but technical expertise and experience.

The table below shows the evolution of AIDS activities in the country.

[27]

[28] Not all figures in this table fit the figures in the next table.

Table 3: Chronology of HIV/AIDS activities in Angola

1985	First AIDS cases
1987	Ministry of Health created technical working group with Ministry of Education, armed forces, university National AIDS programme and launched a youth targeted programme
1991	Outcome of first multi-party elections not accepted by UNITA and war resumed
1992	Creation of AIDS umbrella organization ANASO
1998	UNAIDS office opened in Angola
1999	1st National Strategic Plan 2000-2002
2001 June	Approval Programme to Prevent Vertical Transmission of HIV Some useful experiences since 1985 but the war effort and basic social services had priority
2002	Signing of Luena peace agreement, demobilization of soldiers, refugees start returning
2003 October	Creation of: National Commission for the Fight against HIV/AIDS and Major Endemic Diseases – chaired by President with 15 ministers as members; policy body to ensure engagement of all sectors Technical Commission for the Fight against HIV/AIDS and Major Endemic Diseases – Deputy Ministers of the above.
2002	Ministry Public Administration, Employment and Social Security (MAPESS) launched a national campaign on "HIV/AIDS in the Labour World: Dangers, Prevention and Cautionary Measures"
2003	PSI survey on Sexual Knowledge, Attitudes and Behaviour among Urban Youth
2003	2nd National Strategic Plan 2003-2006
2003	Regulations on AIDS, Employment and Vocational Training
2004 October	Basic Law on Social Protection establishes a comprehensive system with 3 kinds of social protection: basic, mandatory and complementary social;
2004 November	Law on HIV/AIDS – important instrument for defending rights and for strengthening national response to the epidemic, specifying the state's responsibilities, guaranteeing the rights and duties of PLWA

2004 AIDS Funds	**Entity**	**Amount**	**%**
	MINSA	$7.7 million*	22.6%
Most from external agencies	Other mins.	$1.2 million	3%
	International NGOs	$20.5 million	60%
	Companies	$1.8 million	5%
	National NGOs	$2.0 million	5.8%
	UNAIDS	$1 million	2.9%
	Total	$32.2 million	

2005	Major budget increases that will have an impact a couple of years into the future
2005 March	Creation of the National Institute for the Fight against AIDS (INLS)
2005 March	World Bank Hamset (AIDS, Malaria and TB) project effective US$ 21 million
2005	UNICEF Country Programme Action Plan 2005-2008 UN Development Assistance Framework 2005-2008 Preparation Norway-Sweden Joint Inter-sector Programme (NSISP)
2005	NSISRA funded Campaign on AIDS in Schools
2005 September	Agreement on RAAP with launch and data collection but little MINARS involvement
2005 Oct.	Global Fund grant started Phase 1: US$27.6 million
2005	Inter-Sectoral Response to Aid exchange of letters agreement signed by Norway - $3 million
2006	Conclusion RAAP and report
2006	CATVs in each province
2006 January	First national meeting of CSOs working to fight AIDS
2006 June	Campaign "Youth in Free Time"
2006	Hamset (World Bank) KAB survey in six provinces
2006	Creation network of PLWA
2006 November	UN Joint Programme in Support of Strategic National Plan
2006	Preparation 3rd National Strategic Plan

2007	3rd National strategic Plan 2007-2010 Angola has units for prevention, treatment, care and support in all 18 provinces, with 37 units providing integrated CAT, PVMTCT, ARV services and 83 CATs
2007 June	Government commitments on the child in Angola: Commitment 9 - Prevention and Reduction of the Impact of HIV/AIDS on families and children
2007	Revision of UNDAF to reflect the changes that have taken place since 2005

*The planned GOA allocation for AIDS in 2005 was $31.2 million but the eventual budget allocation was reduced to $7.7 million.

Why the revision of UNDAF

In late 2007 the UN system in Angola organized a review of the UNDAF as it had proved to be an unwieldy tool that was out of tune with the country's reality. The main problems with the original UNDAF were:

- Flawed factual basis for much of the analysis
- Overambitious targets and forecasts of donor contributions
- Little or no GOA ownership in defining priorities
- Ignored UN programme formulation guidelines. Instead of designing agency programmes to match overall agreed objectives agencies put forward their ongoing activities and identified objectives that fit them;
- Agencies still in a transition phase from conflict/emergency to development
- Little consideration of the required rights based approach
- No strategic prioritization and uneven detail across agencies
- Limited consistency and coherence in the matrix

As regards the Monitoring and Evaluation system:

- 3 UNDAP and 20 country programme outcomes with an excessive number of indicators, uneven levels of detail and virtually no baseline data;
- Means of verification were too passive, primarily agency or government reports, and ignored the fact that GOA was unable to produce the required data
- Generic risks and assumptions

The UNDAF document was never formally signed by either the government or the UN agencies and was never actually used as a strategic planning and monitoring tool. The revised Results Matrix process reduced the number of Outcomes and Outputs and reformulated the outputs to make them more realistic, specific and monitorable.

Some aspects of the NSISRA document reflected similar shortcomings, in particular the absence of an appropriate M and E system.

By 2006 there were CATVs in all provinces, and PTV services /ARV treatment in all provincial capitals.

Table 4: CATV, PCTV and ARVT activities identified by the RAAP (February 2006)

CATV*		PCTV	ARVT
Feb 06	18	11	9
	9 Luanda		
	3 Cunene	6 Luanda	6 Luanda
	1 Huila	1 Cunene	1 Cunene
		1 Huila	1 Huila
	1 Uige		
	2 Huambo	1 Uige	1 Cabinda
	1 Benguela	1 Malanje	
	1 Bie	1 Cabinda	
		2004 – 4	
		2005 – 7	
Oct 2006	All 18 provinces	All 18 provincial capitals 18+	All 18 provincial capitals 18

The RAAF also mentions 35 CATVs in 6 provinces in Feb 2006, most of which established and run by national and international NGOs the faced occasional stockouts of medical supplies and no national policy on their dissemination and sustainability.

ANNEX 3: NORWAY-SWEDEN JOINT HIV PROJECT MONITORING SHEET - SUMMARY

Activities	2005/2006	2007	2008	TOTAL (USD)	used as of 31/12/08	balance
Policy Development and Institutional Capacity Building						
Technical support for policy, procedures, planning, and guidelines	120 000	105 000	110 000	335 000	437 720	-102 720
National HIV Seminar and Youth Forum/Youth Reviews	150 000	150 000	0	300 000	6 957	293 043
Planning (provincial and national) and training with institutional partners and stakeholders	45 000	35 000	35 000	115 000	25 000	90 000
Subtotal	315 000	290 000	145 000	750 000	469 677	280 323
HIV Prevention through Schools and Communities						0
HIV campaigns in schools- educational materials, training	250 000	100 000	60 000	410 000	269 612	140 389
Materials, equipment, and training for School HIV clubs/Out of School Youth – youth magazines, radio programs	330 000	300 000	300 000	930 000	508 694	421 306
Supplies, training, and communication materials for Out-of-School Community Model	680 000	380 000	410 000	1 470 000	1 887 401	-417 401
Subtotal	1 260 000	780 000	770 000	2 810 000	2 665 707	144 293
Orphans and other Vulnerable Children						0
Situtation assessment of OVCs	20 000			0		0
Subtotal	20 000	0	0	20 000	0	20 000
Clinical and Outreach Services						0
Creation and Expansion of Services and Facilities	400 000	210 000	220 000	830 000	817 013	12 987
Supplies (drugs, safe delivery kits, micronutrients, etc) for PMTCT	270 000	280 000	290 000	1 105 000	588 137	516 863
Supplies for VCT and STI services	535 000	105 000	110 000	410 000	101 526	308 474
Training	60 000	45 000	50 000	155 000	103 064	51 936
Subtotal	1 190 000	640 000	670 000	2 500 000	1 609 740	890 260
Monitoring and Evaluation						0
Post-campaign Assessments	35 000			35 000	5 128	29 872
Household health survey (HIV Module)	80 000			80 000	0	80 000
End of Project KABP survey			130 000	130 000	0	130 000
Subtotal	115 000	0	130 000	245 000	5 128	239 872
Field Implementation and Operations						0
Field Implementation and Operations	293 694	182 793	177 793	654 280	778 323	-124 043
Subtotal	293 694	182 793	177 793	654 280	778 323	-124 043
Programmable Total	3 193 6941 892	1 892 793	1 892 793	6 979 280	5 528 575	1 450 705
Recovery Cost*	351 306	208 207	208 207	767 721	486 403	281 318
TOTAL	3 545 000	2 101 000	2 101 000	7 747 001	6 014 978	1 732 023

ANNEX 4: SUMMARY OF THE NATIONAL STRATEGIC PLAN 2007-2010

Component 1: Management and Institution Building

General Objective 1:
To build national response capacity in the fight against the HIV and AIDS epidemic

Specific Objective 1.1

To strengthen the National Commission, Provincial Committees for the Fight against AIDS and the National Institute for the Fight against AIDS in order to expand actions in the political sphere and mobilize financial resources to fight the HIV and AIDS epidemic at various levels.

Subcomponent 1.1 Strengthening National Commission, Provincial Commitees, INLS

- Strengthen and regulate the national and provincial AIDS Commissions and make the provincial commissions operational
- Create conditions for INLS to become operational
- Revision and implementation of national and provincial operational plans
- Strengthening the technical capacity of INLS through temporary contracts
- Improving the coordination of interventions at all levels
- Promoting the inclusion of HIV and AIDS in all (public and private) sector interventions

Specific Objective 1.2

To mobilize the government, civil society, public and private companies, in particular petrol and diamond companies, to increase the inclusion of HIV and AIDS in their interventions.

Subcomponent 1.2 Articulation with civil society

- Strengthening partnerships with NGOs at national and provincial level
- Strengthening the organizational capacity and response of civil society

Specific Objective 1.3:

To strengthen the epidemiological and HIV and AIDS behavioural surveillance system

- Improvements to the data collection system and the flow of inter-provincial and national information (incidence of cases)
- Strengthening and expanding sentinel surveillance of HIV and STI

Specific Objective 1.4:
To monitor and evaluate the national response to HIV and AIDS

- Establishment of the national monitoring and evaluation unit in the INLS
- Creation of an M&I information system with an integrated flow to the epidemiological surveillance information system.
- Integration and dissemination of M&E in the epidemiological bulletin information

Component 2: Promotion and Prevention

General objective 2: To reduce the spread of the HIV epidemic

Specific objective 2.1:

To promote changes in risk behaviour, attitudes and practices in the sexually active population between 15 and 14 nine years of age

Sub-Component 2.1 Vulnerable Populations and Intervention Target

- Strengthening national and provincial preventive actions
- Intensifying social mobilization and prevention actions for STI, HIV and AIDS with massive interventions
- Institutionalisation of the fight against AIDS in work places
- Promoting the involvement of churches in the fight against STI, HIV and AIDS
- Development of preventive actions for specific social segments
- Integration in the formal and informal education system of content on preventing the transmission STI, HIV and AIDS in family life, sexual and reproductive health
- Development of preventive actions to for the vulnerable populations defined in the strategic plan

Sub-Component 2.2 Educational campaign and material

- Developments of IEC campaigns and material for target populations

Sub-component 2.3 Promoting the use of condoms

- Acquisition of male and female condoms, organization of distribution logistics and coordination of distribution activities with other institutions

Sub-Component 2.4 Counselling and Voluntary HIV testing

- Development of Counselling and Voluntary Testing programs
- Expansion of CVT centres in 59 priority municipalities

Specific objective 2.2:

To establish a concrete system of legislation and norms on HIV and AIDS and guarantee respect for the human rights of people infected with and affected by HIV and AIDS.

Subcomponent 2.5 Stigma and discrimination

- evaluation of the impact of the law on AIDS
- guaranteeing respect for the rights of the HIV + person in work environments
- reduction of stigma and discrimination

Specific objective 2.3: Strengthening the national haemotherapy and biosafety system

Subcomponent 2.6 safe blood

- strengthen control over blood for transfusions and their derivatives at national level

Subcomponent 2.7 bio-security

- prevention of the blood transmission of HIV through sharp instruments

Specific Objective 2.4 Reduce the HIV vertical transmission rate and offer care for HIV+ pregnant women

Subcomponent 2.8 Vertical HIV Transmission

- Increase ARV coverage in antenatal services

- Improve access to ARV in all CPN units
- Guarantee ATV in delivery rooms
- Expansion of assistance to HIV+ pregnant women
- Guarantee access to drugs for the PTV protocol
- Reduction in vertical transmission through the mothers milk

Component 3: Assistance

General Objective: To mitigate the socio and economic impact of HIV and AIDS on the individual, the family and the community

Specific Objective 3.1/3.2

To promote integral care for people living with HIV and AIDS: psycho social support, medical treatment and drugs

Subcomponent 3.1 Access to ARV and drugs for opportunistics infections (IO) for adults, adolescents and children

- Promotion of access to ARV and drugs for opportunistic infections (OI) for adults, adolescents and children
- Preparation of protocols and care flows
- Organization of the service network (decentralized and hierarchical)
- Training health professionals in the clinical treatment of PLWA
- Creation of adherence groups and mutual support groups
- Creation of capacity for palliative care in health units
- Monitoring and treatment of adverse effects
- Treatment of other relevant co-infections in the region (hepatitis).
- Attention for victims of sexual violence
- Monitoring resistance to ARV (research projects)

Subcomponent 3.2 TB/HIV co-infections

- Development and implementation of prevention strategies and approach to TB/HIV co-infection
- Surveillance of HIV prevalence among TB patients

Specific objective 3.3:
Strengthen the national network of laboratories for STI/HIV and AIDS

Subcomponent 3.3 laboratories

- Develop the referral laboratory network for the diagnosis and follow-up of HIV and opportunistic infections

Specific Objective 3.4 Reduce sexually transmitted infections (STI)

Subcomponent 3.4 STI

- Syndrome Treatment of STI

Component 4: care and support

General Objective: To mitigate the socio-economic impact of HIV and AIDS on the individual, family and community

Specific objective 4.1:

To develop and implant a policy of social protection for children affected by AIDS based on the Convention on the Rights of the Child and national policy

Subcomponent 4 .1: Orphans and children affected by AIDS

- Identification of orphans through a retrospective survey of information on consultations.
- Inclusion of social protection mechanisms for children affected by AIDS in national policy based on the Convention on the Rights of the Child
- Study on the preventing and reducing the social and economic impact of HIV and AIDS on families and children.
- Mobilization of the private sector on social responsibility in supporting PLWA;

Specific objective 4.2:

To mobilize public and private partners for the implementation of projects that care for and support PLWA

Sub-component 4.2 People Living with HIV and AIDS

- care and support for people living with AIDS through their inclusion in health care services and civil society organization's.

Summary Budget 2007-2010

USD million

Component	2007	2008	2009	2010	Total
1. Strengthening Management	2.2	5.4	4.1	5.8	17.5
2. Promotion and Prevention	21.0	15.2	22.0	13.5	71.6
3. Assistance	13.8	20.8	30.0	42.4	107.1
4. Care and Support	1.3	1.9	2.8	4.9	11.0
Total	**38.2**	**43.4**	**59.0**	**66.6**	**207.2**

Source of Resources by Component

USD million

	Gov. budget	Global Fund	World Bank	Other	Total
1. Strengthening Management	9.0	6.4	1.9		17.5
2. Promotion and Prevention	43.9	18.1	8.8	0.75	71.6
3. Assistance	60.7	45.6	0.5	0.30	107.1
4. Care and Support	4.6	4.8	1.6	1.0	10.9
Total	**118.4**	**74.9**	**12.9**	**1.0**	**207.2**

Summary of Targets for Universal Access

1. Strengthening Management

Indicator	Current Situation	Targets	
		2008	2010
Provincial committees	3 provinces	18	18
Resources	$30 million	$38.6 million	$61.5 million
Epid. Surveillance	23 referral services	60 strategic sites	82 sites
Sentinel sites for pregnant women	26	35	44
M&E system	Plan	System implemented	?? of analyses and incorporation into management

2. Promotion and Prevention

Indicator	Current Situation	Targets	
		2008	2010
Vulnerable population		20 projects, 59 munic.	40 projects, 80 munic.
Condoms	30 million male 28,000 female	40 million male 60,000 female	76 million male 100,000 female
HIV diagnosis	70% blood tested for HIV, syphilis, hepatitis B	100% blood tested for HIV, syphilis, hepatitis B+C, malaria	100% blood tested for HIV, syphilis, hepatitis B+C, malaria
Prevention vertical transmission	16.3% 1,427 women	40% 5,234 women	70% 9,158 women
PTV control ANS	37 of 1445 ANS	75% ANS	100% ANS
ANS Antenatal service			

3. Assistance

Indicator	Current Situation	Targets	
		2008	2010
PLWA monitored	11,000		
Access to ARV	6.6% (7,859 PLWA)	20% (25,000 PLWA) 100% of PLWA identified	50% (60,000 people) 100% PLWA identified
PLWA assistance services	23 services	82 services in 59 municipalities	99 services in 59 municipalities
ARVT for children living with HIV	778 exposed children	100% of children diagnosed	100% of children diagnosed

4. Care and support

Indicator	Current Situation	Targets	
		2008	2010
Care + support for AIDS orphans	64,000 orphans need support (in a universe of 160,000 orphans)	8,190 children (12.7%)	35,369 children (55%)
PLWA services acting with NGOs to provide care and support	5 services	60 (73% of services with partnerships)	103 (85% of services with partnerships

ANNEX 5: LIST OF IRHA PROJECTS/ACTIVITIES IDENTIFIED BY THE REVIEW TEAM

Title, Agency Period	Intended Beneficiaries	Activities	Budget (rounded) and budget items
Mass Campaigns			
Awareness Campaign in Schools 2005 **Min Education HIV/AIDS** Prep March-Sept 2005, campaign Sept.- December **10 months**	• 689 trainers • 9,000 teachers trained • 614,300 pupils + staff in 855 schools • journalists	• Education material – books, posters, manuals • Teacher training • Supervision/monitoring classrooms • Communication • Media events • Expansion ATV demand	**Budget ?** See activities
Youth in Free Time **Min. Youth +Sport, RNP+ NGOs** BBC World Service Trust June 2006-August 2007 **15 months?**	• 3 million people • 42 radio producers • 40 DJs in workshops • 2,500 youth theatre activities • 53,000 around Afrobasket • 5,000 AIDS Day music festival • 5,000 youth handball tournament	• Production/ dissemination IEC materials; • Mobilisation potential partners • Cap. building study visits • Activities + commemorative events • Travel promote network • Music festival • Afrobasket activities • Strengthening RNP+ • RNP+ travel to Brazil • Youth meeting Luanda	**Budget ?** See activities • consultancies
Clinical and Outreach Services			
Prevention ITS/HIV/AIDS infections Benguela **Medicos do Mundo/DPS** **12 months**	• 5,000 antenatal consultation • 400 HIV + pregnant women • Training 10 traditional midwives, laboratory staff;	• Operation CATVs services • Training/refresher courses • 2 PMTCT services • IEC activities • Data collection + treatment • Training counsellors,	**Budget: $598,000** • 1 fixed, 1 mobile CATV + radio • Medical supplies • IEC materials • 1 4x4 vehicle • Salaries/subsidies
Control HIV Ombandja, Namakunde, Cunene **CUAMM** 12 months Result of visits to province + decision to support Provincial Plan	Staff trained Tested 4,742 men + 7297 women (1372 pregnant) Aug 05-April 06 Pregnant women tested 1057 • AVT: 921	• 2 fixed, 1 mobile CATV • 3 PMTCT centres • IEC and lectures • Data collection and treatment	**Budget: $223,000** • Salaries • Medical Supplies • Vehicle • Equipment • Medical Supplies • Travel • 3 CATV centres
Prevention ITS,HIV/AIDS Benguela **ATMS** 12 months	• 61 CATV personnel, midwives trained • 24 activists • ? pregnant women • ? adolescents, youth	• Expansion/strengthening ATV/ITS services (mobile) • Establishment 2 PMTCT centres • IEC Adolescents + youth • Training/refresher courses	**Budget: $143,000** **UNICEF $82,000** Salaries/incentives • Vehicle 4x4 + radio • Equipment: 2 computers, printer, office equip., 3 photocopiers • 1 mobile CAT • Medical supplies

	No figures given	• Data collection + treatment	• IEC materials • Office materials • travel
Total Control of Epidemic in Cunene **ADPP** 2 years	• 400,000 educated • 100,000 mobilised VCT • 40,000 PMTCT • 32,000 activists counselling • 400 activists psycho-social support • 4,000 PLWHIVAIDS nutrition education • 200 orphan committees	• Baseline survey • Training • Mobilisation population, clubs, schools, workplaces • Field libraries	**Budget US$795,000** • Salaries • Printed material • Uniforms • Motorbikes, bikes • Equipment: digital camera, furniture • Running costs
DPS Cunene Support for PTV + Paediatric Treatment 12 months	No figures	• Improve service quality CPN,ATV,PTV,TARV including mobile clinic • Training 10 community assistants, 4 statistical agents,1 audio-visual agent • Data collection + treatment • IEC audio-visual material for NGOs • Coordination meetings	**Budget US$ 96,500** • Motorbikes + bikes • Salaries/incentives • 2 laptops, 2 computers, 3 photocopiers, 1 back projector, generator, TV, • Mobile clinic • Running costs
Paediatric AIDS Support			
Hope: Care + support for HIV children in Luanda **AAVIH** 14 months	• 700 children 0-12 years • 30 godparents	• Training godparents • Home care + psycho-social support • IEC material production, distribution • Support child consultations	**US$ 280,000** • Staff salaries • Vehicle • Computer, printer, photocopier, office furniture • Running costs
Counselling + Psycho-social support Luanda Paediatric hospital **Christian Children's Fund** 15 months	• 4000 parents • 1,000 infected + non-infected children • 25 trained home activists	• Training activists • Counselling/support sessions • Home support	**US$ 527,000** **UNICEF $447,000** **CCF $80,000** • IEC material • Vehicle (2?) • Furniture, generator audiovisual, computer, printer, photocopier • Rehabilitation training centre • Running costs

Life Skills			
Life Skills Centres Benguela **Caritas** 8 months * see history of support Phase 3: May-December 2006	Beneficiaries Direct: 49,642 Indirect: 24,821 Total: 24,821 Course Volunteers Adolescents + Youth aged 10-25 in religious institutions, HIV+ youth Direct: 75,000 Indirect: 107,655	• Training in 4 learning centres • Creation youth groups • Youth Councils • Sport + other recreational activities • Training trainers -80 teachers in 12 pilot schools, life skills	**Budget: $484.000** **UNICEF:** **Dept AIDS $342,000** **Dept Ed. $101,500** **Caritas $41,000** • Salaries, Rent • Furniture • Equipment: TV, video, generator, laptop, tents, vehicle • Sport gear • Running costs • Rehab. centre • Printing manual • Travel
Episcopal Conference Angola + Sao Tome (CEAST)		Development life skills inside + outside the church	
National Secretariat Lay Youth (NSLY) Phase 1: 9 months		• Dissemination/advocacy African Youth Charter • Life Skills • Voluntarism • Posters, leaflets etc. • Provincial meetings	**Budget** **UNICEF $114,455** **+ $108,000**
National Youth Council 19 months?			
United Methodist Church 4 months +	Target 60,000	• Annual conference	**Budget: $69,000**
Angola Biblical Union 12 months		•	**UNICEF 81,800** **ABU $8,000**
Lay People for Development		• Youth Observatory • Youth + Free Time • Life Skills	**UNICEF $75,000** **LPD $40,000**
Other projects			
Impact Mitigation **ADRA** 12 months	500 families AIDS affected/infected	• Promotion agriculture • Mobilisation HIV-AIDS • Revolving fund • Distribution seeds, animals, mills • Community shops • Community committees • Protection HIV/AIDS children + mobilisation HIV-AIDS • Pedagogical materials • Literacy work • Training • Lobby, advocacy for communities • Promote marketing	**Budget: US$348,500** • Salaries • Seeds, tools, animals, mills, ploughs, cattle, goats • Rotating fund • Running costs • Lorry hire • Land cruiser • 2 motorbikes • Equipment: Computer + printer, furniture • Consumables + running costs
Radio against SIDA: **Radio Cunene**	Adolescents + youth in Kwanhama and Namacunde municipalities	• Training • Production spots • Impact survey	**Budget: $** • Vehicle • discs • Consumables
Life is Stronger than AIDS **PLWA** 13 months **= *Strengthening National Network of***	• 1,200 infected people receive counselling, home care • Cap.building 15 RNP+ nuclei for counselling, referral, management mutual aid groups, home care	• workshops • conception and training in data management tools • exchange visits • assistance to nuclei: planning, counselling • Production IEC material • home and hospital visits	**No data**

PLWA?		• Regular lectures • Disseminate information	
Other activities			
KAP Survey 2006			
Communication Strategy			?
Other??			

* NB History UNICEF support Phase 1 plus 2 extensions:

- Phase 1: July 2003-June 2004 $779,449 12 months
- 1st extension June 2004-Feb 2005 – 9 months
- 2nd extension, March-May 2005- 3 months
- Phase 2: July 2005 -April 2006

ANNEX 6: INTER-SECTOR RESPONSE TO HIV-AIDS IN ANGOLA SYSTEMATIC PROGRESS REPORT SUMMARY BASED ON ANNUAL REPORTS AND INTERVIEWS

1. Policy Development and Institutional Capacity Building

1.1 Output: Protocols/guidelines for STI, VCT, ARV, PMTCT and breast feeding applied Planned Budget: $750,000

Indicator 1.1.1 Approval, application into regulation and practice of new protocols and guidelines

UNICEF provided strong input for the National Strategic Plan for the Fight against HIV/AIDS but not under this programme.

INLS has weak technical-scientific knowledge. Brazil has the most influential programme in this field, although its inputs are not necessarily always appropriate for the Angolan context. UNICEF has provided some initial technical input through its staff's participation in UN Joint Team efforts.

The main UNICEF contributions under the Norway-Sweden funded programme have been:

a) Support for national guidelines on feeding HIV-exposed children
   - Seminar to gain consensus around the guidelines and secure validation.
   - 40 provincial health practitioners and nutritionists trained in 2006
   - Support for INLS production of infant feeding manuals for primary health care staff, community health workers

   UNICEF organised a meeting with the different actors to present the work, discuss topics and guidelines and adapting WHO documents on HBC/PLWA.

b) In 2007, working group on home-based care guidelines led by INLS with support by UN Joint Programme and UNICEF playing a leading role. UNICEF organised meetings with different actors to present the work, discuss topics and guidelines and the adaptation of WHO documents to the needs of primary health workers. UNICEF is also playing an advocacy role in on the crucial need for a horizontal approach to primary health care.

   - Manual for HBC is being finalised (who by, still under UNICEF programme?)

c) In 2007 the first national communication strategy
   - UNICEF supported INLS coordination efforts and funded a team of consultants and a working group of various ministries, UN agencies and civil society, including PLWHA.

- A consultant subsequently prepared a good practise report.

The communication strategy is a policy document and was requested by INLS. The work was very participatory and greatly improved INLS/UNICEF communication. Work on the strategy was also financed by the Global Fund.

Indicator 1.1.2 # health practitioners and midwives trained in new protocols

a) Training under UNICEF pilot projects:
   - CUAMM "*Control of HIV Ombandja, Namakunde, Cunene*" UNICEF $317,000
     - 2 midwives and 4 nurses trained in VCT, STI screening and treatment, PMTCT and follow-up of ART.
   - ATMS "*Prevention ITS, HIV, AIDS Infection in Benguela – Mobile CATV"* $82,000

     - 25 health practitioners trained in universal precautions and CBC techniques.

b) Trained by INLS in 2007 with support from other sources: 522 health professionals
   - 230 nurses
   - 202 medical doctors
   - 49 laboratory technicians
   - 41 pharmacists

Output: Provincial action plans for combating HIV/AIDS completed and rolled out Planned Budget: $

Indicator 1.2.1 # provinces that design and approve action plans

UNICEF's input was limited to some advocacy and pressure. The 18 provincial plans were done by INLS probably with Brazilian cooperation.

Output: National seminar for inter-ministerial commission on HIV/AIDS completed and each participating ministry with HIV/AIDS Action Plan UNICEF Budget $

Indicator 1.3.1 # of ministries with their action plans completed

Not done. The seminar has not yet been held. The INLS director has orally requested UNICEF assistance but its inputs are not yet clear. The seminar might be held around March 2008. In the meantime each ministry has gone ahead and prepared its own action plan (with little or no UNICEF involvement).

Key Results: Women Leaders and market vendors sensitised to gender, self-esteem and HIV/AIDS issues and acting in their venues to increase awareness and preventive behaviour.

Budget: $80,000?

Indicator 1.4.1 # women vendors trained

Indicator 1.4.2 # women leaders participated in round table

Indicator 1.4.3 Follow-up action in terms of further training and outreach

When the Norway-Sweden programme was prepared in 2005 the Joint Programme was weak and UNICEF was the leader. But as the Joint Programme has evolved others are taking on a bigger role. The WB HAMSETT is working with 8 ministries on HIV in the workplace. There might be some UNICEF intervention in roll-outs.

In 2007 there was no special campaign on women vendors but discussions have started with the Ministry of youth and sport about integrating the youth in their free time program into the Ministry is over all young and goal at program. Through that program, women vendors and other marginalized groups will be targeted. Women vendors were also identified in the national communication strategy as a vulnerable group in need of special attention. The end notched prevention working group of the U. N. joint program will half to address this issue in 2008.

2. HIV Prevention through Schools and Communities

2.1 Output: 900,000 out-of-school youth aged 9-16, including youth in life skills centres informed about HIV/AIDS and equipped to raise awareness at community level.
Budget: $350,000

Indicator 2.1.1 # of youth active in HIV and educational activities in life skills centres

Through six church and civil society organizations more than 50,000 youth in all 18 provinces were reached by life skills education (on HIV/AIDS, gender, sexuality, human rights and communication skills) in 2007 through NSC based on peer education methods.

Between 2005 and 2007 UNICEF helped Caritas Benguela to reach over 100,000 youth, in particular in the four municipalities where they have centres (Benguela, Lobito, Ganda and Cubal). The manual developed by Caritas has served as a basis for other FBOs and NGOs now involved in LSE.

Caritas has been receiving UNICEF support since July 2003, divided as follows:

- July 2003-June 2004 12 months roughly $780,000.
- 1st extension March-May 2005. 3 months
- 2nd extension July 2005-April 2006

Under the Norway-Sweden Fund $474,000

- Caritas Life Skills Centres Benguela Phase 3: May-December 2006 (9 months)

Indicator 2.1.2 # out-of school youth reached

Indicator 2.1.3 # youth involved who can state three ways to avoid HIV transmission

In 2006 a KAPB study showed that 25.7% of unemployed men and 44.2% of unemployed women in six provinces were able to identify three ways of avoiding HIV transmission. The Global Fund will finance another nationwide KABP study in 2008.

UNICEF's prevention interventions have been implemented mainly with the Ministries of Education, Youth and Sport, INLS and civil society organisations and this has increased young people's knowledge of HIV/AIDS issues. The strategy has been to move away from the simplified ABC of prevention and inform them about HIV/AIDS, getting tested and fighting stigma and discrimination.

The contribution financed by the Norway-Sweden programme was the project:

- "HIV/AIDS and Youth in their Free Time" 15 months June 2006-August 2007.

  There may have been other sources of funds.

In 2006 the Youth in their Free Time programme run by the Ministry of Youth and Sport reached almost 500,000 adolescents through large scale events such as a music festival, the launch of a Youth in Free Time campaign, and an HIV/AIDS awareness CD. In 2007 almost 150,000 youth were reached through the programmes activities and events (e.g. Afrobasket and December 1 HIV/AIDS Day). In 2007 most of the activities implemented were in the provinces, resulting in a larger geographical target

Indicator 2.1.4 # radio programmes produced and transmitted

Indicator 2.1.5 # provinces with youth-aimed radio programmes

23 radio networks throughout the country broadcast a daily HIV/AIDS program and the edutainment show Teste Viju containing questions and answers on HIV/AIDS. UNICEF has also supported the youth show Mo'Kamba, with 2 x 45 minute shows a week produced by the BBC World Service Trust. Under the Youth in their Free Time campaign, in 2006 36 radio producers were trained and equipped and in 2007 they all made an effort to improve their programming on HIV/AIDS. There are also child to child radio programs with HIV/AIDS as a key theme. Following GoA's acceptance of the 11 commitments for children the Ministry of Social Communication assumed responsibility for the program during the 2007 child to child radio workshop. The 10th commitment was to reinforce the role of the media, culture and education in child development. As of 2008 the programme will be coordinated by the Journalist Training Centre in collaboration with the Angola national radio, MCS and UNICEF.

Support under the Norway-Sweden Programme:

- "Radio against AIDS: Radio Cunene" The support comprised training, equipment, a vehicle and some materials to improve its capacity to produce HIV/AIDS youth programs.

Output 2.2: 600,000 children aged 9-16 and 1.5 million primary school children educated about STI and HIV/AIDS and about 60,000 acting as education agents through HIV/AIDS youth clubs and theatre groups.
Budget: $630,000

NB The problem here is that much of this appears to have been done before IHRA programme started.

Indicator 2.2.1 # school students reached with materials and participated in curriculum

In 2005-2006 some 700,000 booklets on gender and HIV were produced and distributed among students through HIV/AIDS and gender clubs in schools.

In 2007, some 18,000 booklets on HIV/AIDS and sexuality, 300,000 leaflets on condom use and 300,000 leaflets on getting tested were printed. They will be distributed in 2008.

Indicator 2.2.2 # children and youth actively participating in HIV/AIDS youth clubs

At the end of 2006 there were 471 clubs in secondary schools, with an estimated [no new date to collection in 2007] 16,000 student participants. In order to support the HIV/AIDS and gender clubs, training sessions on gender and HIV/AIDS were held in seven provinces in 2007 reaching over 1000 young people.

Indicator 2.2.3 # of children/youth participating in HIV/AIDS theatre competitions

National festivals in all provinces in 2005 and 2006, with all most 10,000 participants, reached about 400,000 youth. In 2007 provincial music and dance festivals were held in six provinces to mark international HIV/AIDS Day, 1 December 2007, reaching an estimated 2000 schoolchildren.

Indicator 2.2.4 # schools or clubs with student-made magazines

In 2007, materials were bought and an ethical code developed. In 2008 magazines will start production in two municipalities each in three different provinces.

Indicator 2.2.5 # youth involved who can state three ways to avoid HIV transmission

Output 2.3: 9,500 teachers trained and equipped to teach STI and HIV/AIDS curriculum and facilitate participatory dialogue with youth
Budget: $ 1,060,000

Indicator 2.3.1 # teachers trained and received curriculum

In 2005 UNICEF supported training on HIV/AIDS for 8,994 teachers and provided 9,500 teachers manuals. In 2006 UNICEF supported the production and distribution of 700,000 manuals for students on HIV and gender. **NB Again before IHRA started**

In 2007 UNICEF trained 300 teachers from seven provinces in two week-long training sessions on HIV/AIDS and gender through peer education methods. The 15 trainers were trained by UNICEF in Luanda. There were also two coordination seminars looking at the creation and implementation of the MoE HIV/AIDS strategy. The first seminar was held in June and supported by UNICEF; the second d one in December was supported by the World Bank HAMSET programme.

The Norway-Sweden contribution was as follows:

- Caritas Life Skills Benguela

3. Orphans and Other Vulnerable Children

Key Result 3.1: Situation Assessment completed and applicable to designing policies and action plans on OVCs affected by HIV/AIDS

Budget: $20,000

Indicator 3.1.1 Situation Assessment completed

A situation analysis conducted through the Rapid Assessment, Analysis and Action Planning process was completed in early 2006, financed by the DFID contribution to UNICEF. Integrated national action plans and their respective budgets have been developed by an inter-ministerial commission and approved by the Council of Ministers.

UNICEF is support a mapping exercise by the Provincial Office for Social Assistance and Reintegration to identify OVCs in three municipalities in Cunene province. It has identified 11,609 vulnerable children comprising 4,414 orphans of whom 2,439 are HIV/AIDS orphans.

Indicator 3.1.2 Policy, approved, applied and functional ensuring access to necessary protection and services to OVCs affected or infected by HIV/AIDS.

In November 2007 UNICEF supported an OVC M&E workshop attended by 30 MINARS officials from eight provinces. Work is proceeding on the developments of an OVC M&E. framework

As the result of this support the government is developing an OVC national response that includes the conclusion of the OVC national plan of action arising from the RAAP and the expansion of OVC mapping and identification to us the six provinces. The aim is to pilot methodologies, strategies, programs and measures that could provide the basis for an improved social protection framework in Angola.

NB Unclear what, if anything, funded b y IRHA

4. Clinical and Outreach Services

Output 4.1: Functional, equipped PMTCT/STI/VCT/ARV services established in 4 target provinces and mobile outreach services created and covering rural areas; health promoters encouraging pregnant women and youth to get testing.

Budget: $ 610,000

Indicator 4.1.1 # municipal VCT/ARV centres established

With UNICEF technical support the INLS is rolling out VCT services throughout the country. In the first semester of 2007, 43 new VCT sites became operation on, increasing the total to 126 centres nationwide. Given the lack of infrastructure, UNICEF has provided it fully equipped containers to add VCT activities in the three municipalities (2 in Kuando Kubango and 1 in Moxico.) They are linked to mobile clinics to ensure follow-up, care and treatment for clients screened for HIV+. In 2007 UNICEF also donated laboratories kicks, equipment, STI drugs and if the health clinic supplies to the INLS.

Indicator 4.1.2 #mobile VCT/ARV services functioning

Indicator 4.1.3 % municipalities covered by mobile VCT/ARV services

UNICEF has supported 2 VCT mobile services previously donated to the INLS IN Benguela and Cunene. The clinics are provided in STI, VCT, behaviour change and social mobilization services in areas are from health facilities. All of Benguela's nine municipalities are covered by mobile VCT services [547 people tested from May to December 2000 7], and five of the six municipalities in Cunene are also covered [1000368 people tested in 2007].

In 2007 UNICEF donated 3 mobile clinics (Moxico, Kuando Kubango and Lunda Sul] to provide comprehensive services [ANC, PMTCT, HIV care and treatment] in 6 fixed VCT services in six municipalities. This is a pilot strategy adopted by INLS to address the lack of technical and human resources.

Norway/Sweden IRHA programme supports the following projects:

- Medicos Mundo
- CCF
- ADPP
- DPS Cunene
- Uige equipment?

Indicator 4.1.4 # youth and pregnant women getting STI testing

In order to promote increased uptake of STI testing in VCT and ANC services UNICEF introduced this activity in the projects it is support sitting as part of the mobile clinics in Cunene and Benguela and the Cuamm project in Cunene. Between May and December 2007 Benguela's mobile clinic screened positive and treated 149 people. In Chiulo hospital (Cunene) syphilis and hepatitise B are systematically screened during ANC and 669 tested positive and were treated in 2007.

Output 4.2: At least 70% of all HIV+ pregnant women get PMTCT treatment and post-partum support for ARV and nutrition assistance Budget $ 815,000

Indicator 4.2.1 % coverage of pregnant women accessing VCT services in all municipalities

From January to September 2007 58,611 pregnant women accessed HIV testing in Angola through ANC. In Cunene province to thousands 827 pregnant women were counselled and tested during the period January to November 2007, which is 9.8% of the 28,808 seat pregnant women in the period. 145 were HIV positive and 66 of them [45.5%] were enrolled in PMCCT.

Norway/Sweden IRHA funded contribution:

- CUAMM Cunene, tested 1237 pregnant women with the T3 HIV-positive women enrolled
- ATMS Benguela tested 181 pregnant women during the period May -- December 2007.

Indicator 4.2.2 # of municipal PMTCT centres established

Between 2004 and July 2007 the number of services rose from from two to 48 PMTCT and 50 ART services. UNICEF has contributed laboratories materials, ARVS and at the health clinic consumables. It IS also providing donations in kind to improve the quality of ANC and maternity services as pops of the integration of PMCCC services.

In 2007 UNICEF organized a workshop for full province says to analyze the quality of PMCCC and ART services and to prepare my crow -- improvement plans. Supported by UNICEF Khomeini province has begun to implement the micro plan particularly for the award the nation, supervision, monitoring and peer review meetings.

Indicator 4.2.3 % of mobile PMTCT services functioning

Three mobile clinics were donated to INLS in 2007 to ensure PMCTC and ARV outreach services in six new municipalities in three provinces. The clinics are provided being comprehensive referral services to ensure prevention, diagnostic and care for various complicated Obstet obstetric and infectious diseases including PMCCC and THEY are see, in municipalities that do not have the permanent doctors.

Output 4.3: Midwives and health technicians trained in HIV/AIDS and given technical training in performing PMTCT, VCT, STI and ARV duties.

Budget: $300,000

Indicator 4.3.1 # traditional midwives and other practitioners trained and supplied with safe delivery kits.

Norway/Sweden IRHA funded contribution is supporting:

- Christian Children's Fund "Counselling and psycho social support to the Luanda paediatric hospital.

  In 2007 the first group of thirty CWA, including PLHA, was trained and work started on the follow-up of Sauget Co. all all 1000 HIV positive children on the care and treatment in Bernadino hospital [referral hospital for pediatric AIDS in Angola. This is a pilot experiment that will be replicated and scaled up at national level in 2008.

- ADPP CBC project "Total control of the epidemic in Cunene"

  In 2007 200 activists in 4 municipalities were trained and they mobilize 12,296 people for VCT testing and 7200 421 pregnant women for ANC and PMTCT services.

- The CUAMM "Control of HIV in Ombandja, Namakunde and Cunene" project trained 13 traditional midwives to promote VCT and PMTCT among pregnant women.
- The ATMS "Prevention of ITS, HIV, AIDS in Benguela" project trained to see traditional midwives and 35 activists.

(Under the accelerated child survival and development strategy promoted by UNICEF, the community approach to HIV prevention, PMCTC, and HBC within the community and IMCI are being promoted in six pilot provinces.(Luanda, Cunene, Huila, Moxico, Bie and Uige).

Indicator 4.3.2 % pregnant women that get tested for STI and HIV

Not reported

5. Information, Education and Communication

Output 5.1: Clinical and community based information materials produced and distributed to every health facility and outreach health services.
Budget:

Indicator 5.1.1 # facilities/institutions receiving materials

UNICEF provided technical support for the design of protocols, guidelines and training

materials for community health workers (CHW).

Under the ACDS programme, HIV/AIDS training and support materials have been prepared for inclusion in manuals on the Integrated management of childhood illness [c-IMCI). A manual for CHW explaining PMTCT to HIV positive parents has been prepare and is ready to be printed.

Key Result 5.2: One million people informed about HIV/AIDS reached through printed materials Budget:

Indicator 5.2.1 # HIV materials disseminated

Indicator 5.2.2 # people reached with materials

Indicator 5.3.1 # teachers, school HIV/AIDS clubs, health facilities, midwives, community and religious leaders that received educational/information materials

The Sweden-Norway programme supported two Government initiatives[29]:

- "HIV/AIDS Youth in Free Time" programme of the Ministry of Youth and Sport;
- "AIDS Awareness in Schools" of the Ministry of Education.

By December 2007 this support had included the production and distribution of:

- 2005-2006: 700,000 booklets on gender and HIV that reached an estimated 3 million students and others through them. (2005-2006)
- 2006-2007: 30,000 posters; 50,000 T-shirts; 100,000 placemats and coasters; 16,500 hats; 15,000 bandannas; 5000 pins and 5000 CDs up to December 2007. Ninety per cent of the material was distributed to young people through various events.
- 2006-2007 A further 50,000 brochures and leaflets were distributed through schools and NGOs, and some 1.5 million booklets, brochures and leaflets on gender and HIV/AIDS were distributed throughout the country.

It is estimated that this material reached around 500,000 youth in 2007, and that some 2 million people have been reached since 2006 through health facilities, schools, youth centres and on festive or commemorative occasions such as:

- World AIDS day, 1 December e.g. music and theatre festivals
- Afrobasket – the African basketball championships held in Angola in 2007, with the involvement of 50,000 young people
- The African Cup football event, held in Ghana early in 2008

Other projects that have contributed to the dissemination of information are:

- Life Skills courses provided through youth clubs, HIV/AIDS clubs in schools and among faith-based organisations, covered by the following projects:
  - Caritas "Life Skills Centres" that began with UNICEF support in 2003 and was subsequently rolled out to other organisations
  - National Youth Council;
  - Lay People for Development;
  - Angolan Bible Union;
  - United Methodist Church

[29] Possibly also support by other donors

- National Secretariat of Pastoral Youth;

- Behaviour change through ADDP "Total Control of the Epidemic in Cunene" that includes awareness raising initiatives in densely populated areas along the border with Namibia, targeting in particular prevention and voluntary testing for young people and pregnant women;
- Similar behaviour change work by the CUAMM and ATMS projects

Output 5.3: 75% of the Angolan population informed about HIV/AIDS through mass media Budget:

Indicator 5.3.2 # aware of radio spots

Indicator 5.3.3 # viewed television spots

Indicator 5.3.4 # radio and television programmes

UNICEF has supported a number of media activities that have received occasional financial assistance from Norway-Sweden funds, including: 6 radio and TV spots linked to the African Cup (reaching an estimated 47% of the population), others linked to Afrobasket, an edutainment "Teste Viju" quiz show on HIV/AIDS aired on 23 radio channels, live broadcast of the AIDS day music festival.

Ouput 5.4: Youth radio programmes produced and broadcast in every province.

Indicator 5.4.1 # provincial youth radio programmes

UNICEF's media initiatives have included the promotion of a youth to youth radio programmes (launched in Cunene province with UNICEF's own funds in 2005, by the end of 2007 it covered 9 of the country's 18 provinces) that are provided with materials for their programmes. The contribution of the Norway-Sweden programme has been mainly:

- Assistance for the Cunene radio station (training, a vehicle, equipment and regular supervision visits) to improve its HIV/AIDS content;
- Some equipment for the Uige station

Indicator 5.4.2 # provinces broadcasting programmes regularly

No information

Attachment with breakdown of expenditure

1. Policy Development and Institutional Capacity Building

Line 01 Technical support for policy, procedures, planning and guidelines
USD 335,000 planned

Activity	Expenditure		Itemised
Activity	Total	Detail	
MCH Specialist	107,000		(amount requisitioned)
nutrition seminar	24,500		(validation national guidelines for HIV/AIDS+ children)
International travel	54,320	10,802	Addis Abeba International Conference
		24,185	Toronto HIV AIDS World Conference
		5,699	Kigali HIV AIDS implementation meeting
		1,303	Mozambique workshop on OVC capacity building (M&E)
		3,681	Mombassa training Human Rights approach to programming
		3,650	registration fee for conference training
		5,000	exchange of experiences/strengthen relations RNP+Angola and xxx
		54,320	
Communication strategy	78,200	5,351	consultation with parties
		656	consultation with parties
		656	consultation with parties
		609	consultation with parties
		834	consultation with parties
		4,694	complement work consultant/review docs. + discussion
		11,400	complement work consultant/review docs. + discussion
		54,000	
		78,200	
Work in Uige	10,142	240	mission Uige
		240	mission Uige
		500	mission Uige
		500	Mission Uige
		662	Driver
		2,142	mission on decentralisation of NSP Uige
		8,000	ANC/PMTCT/paedeatric AIDS servuces and micro plan to improve it
		10,142	Uige Total
Payroll/Salaries	162,638	96,936	IMIS Reprod Officer
		15,000	IMIS Proj.Officer HIV AIDS
		50,702	IMIS Bolanzi
		162,638	
Misc	505	415	Afrobasket follow-up work
		90	accompany DFID mission Cunene
		505	
TOTAL	**437,305**		

Line 02 National HIV Seminar and Youth Forum-Youth Review
USD 30, 000 planned

Activity	USD
Facilitation ANASO training in project cyrcle	963
Seminar on project cycle Cunene	4,950
Meeting with DPS	456
INLS-DPS workshop to discuss and approve activities to expand + increase accessibility + quality of ANC services	588
	6957

Line 03 Planning (provincial and national), training with institutional partners + stakeholders
USD 115,000 planned

Activity	Amount (USD)
Funds advance, primary prevention seminar in the academic system	5,000
HIV/AIDS seminar of Lusophone countries, FESA organised	20,000
Total	25,000

2. HIV Prevention through schools and communities

Line 04 HIV campaigns in schools, education materials, training

Activity	Amount	Detail
National Teachers/School directors HIV training	255,161	148,243
		95,265
		11,653
		255,161
Training HIV national trainers	6,716	
Development + correction HIV training manual	3,000	
Printing HIV teaching materials	4,735	
Total	**269,612**	

Line 05 Materials equipment training HIV clubs, youth magazine, radio programme (USD 410,000 planned)

Activity	Expenditure		Itemised
	Total	Detail	
Africa Cup	3,678	2,358	Nairobi planning meeting
		1,320	radio-tv spots
		3,678	
Dance and Music competition	40,000	5,250	sensitisation Lunda Norte
		4,000	sensitisation Cunene
		5,250	sensitisation Moxico
		10,000	sensitisation Uige
		3,250	sensitisation Lunda Sul
		3,250	sensitisation Cabinda
		9,000	sensitisation Malanje
		40,000	
Music Festival for the Young	30,000		
Training trainers participatory theatre	2,332		
Radio Cunene	4,467	700	decoration Cunene car
		1,667	disks for Cunene
		2,100	training communication tech. Ondjiva
		4,467	
Other	74,946	8,854	Capacity building daily infant radio
		19,124	IT equipment provincial radios
		46,968	Toyota HIV radio + DPS Lunda Norte
		74,946	
Youth Free Time Project			
	123,500	10,500	t shirts
		113,000	t shirts curte vida
		123,500	
Paul Gasol visit	6,722		
HIV Schools Campaign			
Best Practice study	9,789	558	accompany Melody visit
		9,229	study + training trainers youth clubs
		9,787	
Training youth clubs	146,816		
		50,904	peer educators
		87,896	training peer educators 7 provinces
		7,400	training peer educators
		618	
		146,818	
Payroll-Salaries	61,353		Asst Project Officer AIDS
Photo report ANASO festival	2,620		
Meeting working group sport	4,571		
TOTAL	**506,223**		

Line 06 Supplies, Training and Communication materials for out of school community model (USD 1,470,000 planned)

Activity	Expenditiure		Itemised	%
	Total	Detail		
Payroll salaries	201,008	45,000	Prog specialist	11%
		25,813	APO Prog. Com	
		15,313	Asst Prog Comm	
		25,856	APO	
		14,767	Prog Assist	
		74,259	Ass Pr Comm Off	
		201,008		
Life skills	286,089			**15%**
Caritas Project		193,758	CAG	
		25800	CAG advance for AAS	
		18131	training facilitators	
		237,689		
Life skills evaluation		30,500		
Support life skills		17,900		
		286,089		
Youth Free Time Project				**62%**
campaign launch	10,000			1%
BBC Campaign consultancy	371,393	288,491		19%
		17,685		
		65,217		
		371,393		
Teste VIJU + CD copies	13,500			1%
AIDS film	39,746			
CD Angolan artists	12,500			
Senstisation artists café de ideias	428			
publicity material	437,192	131,800	leaflets	23%
		12,890	leaflets	
		8,400	posters	
		240,000	material	
		44,102	material	
		437,192		
CAN handball	75,000	46,472	sensitisation 5 provs.	7%
		28,528	CAN sensitisation 5 provs.	
		75,000		
Afrobasket	127,548	30,000		7%
		15,000		
		3,698	travel to venues-moniotring	
		15,000	cash advance	
		190	travel to expand prog/ establish Afrobasket groups	
		604	Ditto	
		656	Ditto	
		15,000	cash support for activities	
		9,000	Ditto	
		38,400	t shirts	
		127,548		

Travel campaign monitoring	3,946	950		
		1,246		
		800		
		950		
		3,946		
Free Time Misc/General	83,645			4%
		5,049	complement full time consultant	
		35,000	project support	
		2,434	transport campaign material	
		3,485	transport campaign material	
		1,546	travel to provinces	
		400	travel huambo	
		23,032	assistance project coordination	
		7,125	consultancy coordination	
		2,985	local clearance PGM	
		1,500	misc expend.	
		417	acquisition newspaper	
		672	HIV ad newspaper	
		83,645		
World Aids Day	70,179			4%
			31,000 Activities provs. 2006	
			19,179 Aids day + handball 10 prov.	
			20,000 Strengthen. NGOs for 1/12	
			70,179	
Misc.	180,528			
		25,750	CAG advances AAS	9%
		5,281	consultancy soc.comm. AIDS prevention	
		2,060	comm. techniques training cunene	
		4,200	soc comm strategy cunene	
		76,249	reimbursement expenses CAG PSI	
		9,999	transport VCT PMTCT material cunene	
		49,700	printing manual HIV clubs	
		7,289	reimbursement AIDS conference	
		180,528		
	1,912,702			
	(1.887.401	on the expenditure statement)		

4. Clinical and Outreach Services

Line 08 Creation and expansion of services and facilities
($ 830,000 planned)

Item	Expenditure		Itemised	%
	Total	Detail		
Medicus Mundi	39,435	43,125	2nd instalment	5%
		-3,690	2nd instalment	
		39,435		
ADPP	284,676	574	monitoring + assessment	35%
		187,082	cash payment	
		97,020	1st instalment 2nd Q	
		284,676		
Hosp Ped AIDS	8,920	3,285	Chairs	
		3,882	Chairs	
		1,753	Equipment	
		8,920		
CCF	150,938	150,938	1st instalment	19%
DPS Cunene	343	343	Internet	
Supplies	22,223	10,223	190 bikes	3%
		12,000	INLS wooden penis	
		22,223		
Training hospital staff	8,000			1%
Admin	40,779	32,960	clearance charges	5%
		1,015	clearance charges	
		808	Ditto	
		891	Ditto	
		4,500	SASS inspection company	
		605	air freight material cunene	
		40,779		
Misc	259,507	4,476	expenditure PGM 2006/112	32%
		245,721	2nd instalment as per agreement	
		9,310	construction base CATV container Kuit Kwanavale	
		259,507		
Total	**814,821**			
	(817,013 on sheet)			

Line 09 Supplies for PMCT
USD 1,105,000 planned

Item	Expenditure		Itemised		%
	Total	Detail			
Equipment	317,378	10,034	PMTCT	Equipment	53%
		6,600	Ditto	offices	
		1,906	ditto CAM		
		3,362	PMTCT		
		2,362	ditto offices		
		6,281	Equipment Material DPS		
		83,404	40 motorbikes		
		17,610	mobile clinics additional options		
		6,952	IT material		
		73,846	4 VCT containers		
		75,943	Toyota		
		5,041	Amplocor HIV DNA		
		6,715	equipment PMTCT		
		3,542	equipment PMTCT		
		13,780	laboratory vacutainer		
		317,378			
ADPP project	1,588		equipment		
CUAMM project	26,375	10,961	equipment	PMTCT	4%
		2,217	equipment	PMTCT	
		10,412	equipment	PMTCT	
		2,785	photocopier		
		26,375			
DPS Cunene	23,982	10,175	Additional equipment DPS		4%
		7,549	photo, back projector, laptop		
		6,258	motobikes		
		23,982			
Material/Supplies	196,424	720	Material provs PMTCT/DPS		33%
		35,737	ANC,PMTCT, ped AIDS		
		1,428	PMTCT/DPS		
		10,724	AIDS test kits		
		13,644	drugs and material		
		13,510	ditto		
		31,759	ditto		
		31,759	ditto		
		31,759	ditto		
		2,628	material ANC/PMTCT/PED AIDS		
		22,756	material ANC/PMTCT/PED AIDS		
		196,424			
Training	300		translation during training		
Misc	31,448		2nd installment as attached		5%
	597,495				100%
	588,137 on statement				