



Ajuda Humanitária
e Protecção Civil



REPÚBLICA DE ANGOLA
MINISTÉRIO DA SAÚDE



Using Community Volunteers to deliver treatment services for acute malnutrition in Bie, Huambo, Zaire and Kwanza Sul, Angola



NGO Partners: People in Need and Africare
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Background: Malnutrition in Angola

- Program in response to a drought that impacted 2011/2012 harvest
- Very little nutrition capacity - most nutrition NGOs closed in 2007.
- Malnutrition is not recognized at the community level
- Malnutrition is a permanent problem in Angola
- Program is implemented in 4 provinces (Huambo, Bie, Kwanza Sul, Zaire)



Main causes of malnutrition

- Premature weaning of children when mothers are pregnant again – problems with birth spacing
- Early introduction of complementary foods (2-3 months)
- Nutrient-poor complementary foods (usually porridge with sometimes a bit of greens and fish or meat)
- Lack of hygiene in the preparation of food and eating practices
- Unsafe water sources
- Many women believe that when a baby cries or has diarrhea their milk is “weak”



Nutrition Architecture in Angola – 2008-present

3 basic levels

- Unidade Especial de Nutricao (**UNE**) exist in most municipalities for the in-patient treatment of SAM with complications.
- Programa Terapeutico para Pacientes em Ambulatorio (**PTPA**) in health centres are at municipal and communa levels for out-patient treatment of SAM and MAM
- **Beginning in Dec 2012** - Community Health Activists provide treatment of uncomplicated SAM and MAM beyond the coverage area of PTPAs



Govt-
run



WV
Africare
PIN

Program Objective: To scale up CMAM in at least 50% of the Communes in four drought affected provinces of Angola



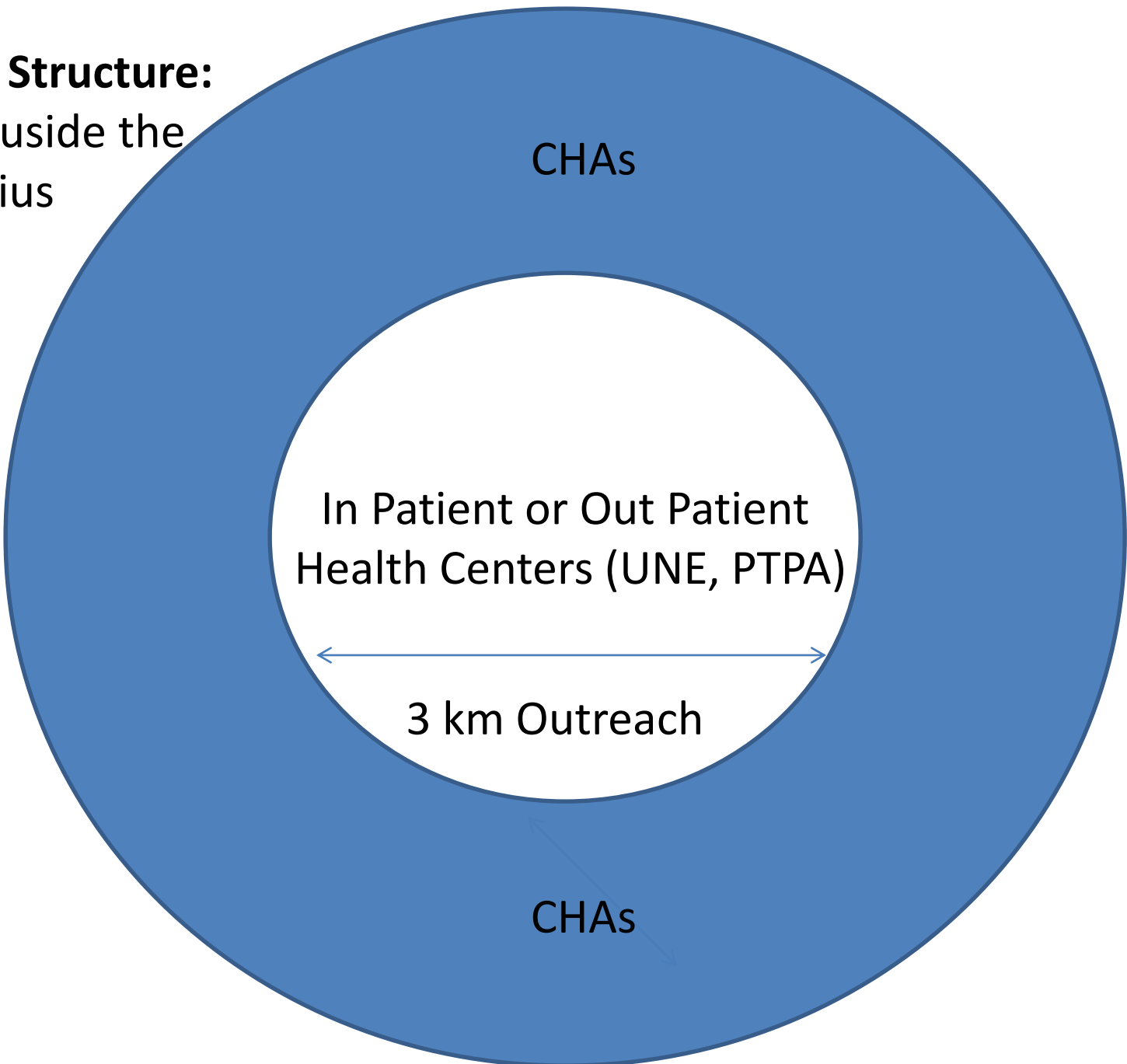
Program Strategies:

- Working with a network of **2,044 Volunteer Community Health Activists (CHAs)** for identification, referral and treatment of SAM & MAM cases
- Community mobilization through “Sobas” and traditional leaders to promote better feeding practices and CMAM activities.
- Working with UNICEF, provincial and municipal nutrition departments ensuring Plumpy Nut and Sup supplies

- **RUF provision** for malnourished children with **SAM** – plumpy nut and **MAM** – Plumpy Sup
- **IEC program** that focuses on feeding practices for mothers with malnourished children – water treatment, food diversification, exclusive breastfeeding

Program Structure:

CMAM outside the
3 km radius



CHAs

In Patient or Out Patient
Health Centers (UNE, PTPA)



3 km Outreach

CHAs

Community Health Activists

- **Recruitment** - by Sobas and local administration
- **Selection Criteria** – literate, respected by community, knowledge of health; many with past experience in community health programs
- **Training** - in detection and treatment of SAM and MAM by WV and partners using UNICEF materials
- **Supervision** - Each group of activists is assigned to one commune and is coordinated by the Commune Supervisor. Supervisor coordinates the CHAs to ensure that they cover all villages in the commune. Responsible for collating nutrition data at the end of each month. MOH staff, often trained nurses.
- **Delivery of Services at village level** – approach varied – some CHAs go house – to –house, others set-up a temporary site for treatment. Present workload 2-3 days/week

Community Mobilization/Outreach

- Coverage of 4 provinces, 21 municipalities, and 76 communes
- Network of 2,044 Community Health Activists
- No outreach within 3 km radius of In and Out Patient facilities—important to have CHAs operational here
- SQUEAC assessment showed an average coverage of 75% the 3 provinces (best performing areas)
- December 2012 - August 2013 a total of **655,514 children were screened** and **21,557 children treated for SAM** and **55,452 children with MAM** by CHAs



Program Outcomes

- Cure rate: 93.14%
- Default rate: 4.97%
- Death rate: 1.75%
(SAM), 0.44% (MAM)



Successes of CHA approach

- Vast network of CHA has expanded the available of treatment services for SAM and MAM
- Close proximity of CHA to communities
 - Long standing relationship with community, are able to support and monitor on a frequent basis
- Good community mobilization strategy using Traditional Village and Church Leaders as focal points.
- CHAs generally demonstrate a sound ability to identify early and treat both SAM and MAM cases as well as refer children with complications to health facilities
- Strong links between the commune supervisors and the CHAs
- Strong interest of women in the community education sessions on IYCF
- Good coordination with the Provincial Health Department and UNICEF

Challenges/Improvements

- Gender imbalance – majority of CHAs are men
- Selection criteria for CHAs – literacy
- Adherence to international treatment protocols – health check, routine meds
 - Children with SAM should go for a first consultation to a health facility for a complete check up and treatment before being further treated at the community level
- Strengthen connection between UNE/PTPA coverage area and community treatment provided by CHAs
 - Children discharged from the UNE (In Patient) should be monitored by the CHWs.

Challenges/Improvements

- Reporting and M&E systems are complex and need strengthened
 - E.g. More appropriate tools needed for CHAs, improve methods for follow-up on referral and discharged cases, improved training on M&E for CHAs
- Although the working relationship with the Provincial Departments of Health are good, more direct involvement is needed.
- Significant stock-outs of RUTF/RUSF due to national shortage
- Increase engagement of men to attend IYCF sessions

Recommendations

- CHWs working in teams produce better quality work
- Advocate for CHAs to be included in the health service to ensure better outreach (GoA is working on a policy)
- Standardize CHA motivation and incentives
- The GoA will need to ensure a stable and regular supply of RUTF, RUSF, therapeutic milk and meds – possibly the establishment of a local RUTF and RUSF production capacity
- Ensuring routine meds are provided
 - Mobile medical teams
- The implementation of a longer term nutrition program in Angola with a specific focus on capacity building in the areas of IYCF, reproductive health, wat/san.

Final Thoughts...

The use of a large, and far-reaching network of CHAs enables the most remote communities to be reached.

The proximity of the CHAs to the communities also enables strong monitoring of children, close tracking and follow-up of treatment.

Considering the limited number of PTPAs and health centres, a community-based approach is clearly the most effective method to reaching children in Angola.

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