Recommendations for improving the quality of CMAM programs in Angola based on experiences from Cunene province to support future work on a national scale up plan

Jose Luis Alvarez Moran (Tech RRT CMAM Advisor)

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Scope and warning

During the Rapid Response Team´s CMAM advisor deployment it was expected that the "*CMAM Advisor will hand over his work to the UNICEF team including a surge staff member scheduled to arrive in November 2019 (2 weeks before the deployment ends)*" as written in the ToR. This surge team member should take the bottlenecks identified and the solutions presented in the Bottle Neck Analyses (BNA) to guide the UNICEF team in developing a work plan to scale up a quality CMAM service.

Unfortunately the surge staff member could not be available in 2019 and is expected to arrive in 2020. It is of vital importance that the surge team member is available as soon as possible in order to give continuity to the work started here. Since it was not possible to debrief and meet in person in Angola this report should help future staff to create such a scale up work plan for CMAM

This report complements the BNA report but, unlike the BNA reports, is based on individual recommendations, private discussions and sometimes personal opinions of the author. It should not be disseminated externally and should remain as a internal working document for UNICEF Angola and the RTT.

Immediate action points for UNICEF for December and January:

- Write to INE to thank them for their support with designing the SMART survey, specially noting the contributions of Ezequiel and Alfredo.
- Think about the need to conduct a Rapid SMART in Kwando Kubango (and maybe other areas of Huila province in early 2020
- Design a strategy to disseminate the results of the SMART survey with care involving INE and MoH so that results are appropriated by the government
- Start advocacy activities in January, maybe creating an advocacy brief with information from
    - Mike Golden´s report
    - BNA analyses
    - SMART survey
- Engage with the surge team to request Sonia to come to Angola ASAP for a period of at least 6 months to work closely with government in creating a costed plan to scale up CMAM

Field observations:

After a few days in the capital meeting with partners and reviewing different documents the RRT¨s CMAM advisor flew to Ondjiva to conduct a monitoring mission and a BNA training. In annex 1the full agenda of the mission that took place from November 3rd to November 10th 2019 can be found. What follows are some observation that can help while developing a CMAM scale up plan.

- *4/11/19 visiting the SC in Ondjiva:* The 13 beds for malnutrition are always occupied. 2 doctors were trained in the new protocol but they are not exclusive for the SC they are integrated in the paediatrics' services. Mortality rates are high. In 2019 there have been 53 deaths of which 9 occurred in the next 24 hours after admission. It is clear that SC´s staff don´t follow the protocol, for example children receive both F75 and pumply nut on the same day.

  They use the paediatric's clinical history to follow up patients in SC and they do not fill up the nutrition "folha de seguimiento". Thus there is no close daily follow up on weight, and when they do some strange data is introduced, for example in 1 day a child can lose 1.5kg.

  We noticed that mothers don´t receive enough explanations at discharge. They receive plumpy nut and a dignity kit but not detail recommendations on its use.

  Approximately only 25% of admissions com from OTP (PTPA) with most of admissions walking in the hospital directly and a few referred from other units.

  MUAC is systematically rounded in all registers.

  SC is well stock and there are no stock outs.

- *4/11/19 visiting the SC in Namacunde*. Very few admissions in this SC 30 minutes south of Ondjiva. Only 2 admissions when we visited. Monthly reports are missing the month of June, they don´t have a CMAM register book. The don´t have updated WHZ tables and it seems they don´t use them much. As in other facilities they are systematically rounding MUAC and they make a lot of mistakes when measuring: they measured 11.5cm in an admitted child while we got 11.1cm. They also forget to do it in the left arm and calculating it in the middle point of the upper arm. As with other SC they have very high mortality rates every month well above sphere standards.

- *5/11/19 visiting the SC in Chiulo*. This SC is in a big hospital supported by the local catholic church and managed by CUAMM. They also have an OTP and raised the concern of sharing plumpy nut. Population uses a lot traditional medicine.

  Most of admissions are spontaneous and there are very few referrals. They had 60 admissions in the last month and they have 8 beds but they have normally 20 (21 when we visited) SAM cases so they occupy the paediatric area. They have 6 nurses and 3-4 auxiliary nurses. Relapse is frequent. Long lengths of stay as in other SC. They have never met with CHWS/ACS and have no interaction with them

- *4/11/19 meeting WV in Ondjiva*. Of the 80 OTPs in the province they support 61 with community activities and some mobile units. We meet with the CHWs coordinator (Isaías) that manages 15 CHWS supervisors that in turn supervise 10 CHW each (ACS/Agentes Comunitarios da Saud). Minimum salary in Angola is 33,000 AOA, CHWs supervisors get 15,000 and CHWs 11000. They have screened 98000 children in 4 months

- *5/11/19Meeting WV´s CHW supervisors in Ondjiva.* MAM cases are rejected since there is no Plumpy Sup. Sharing the plumpy nut at home is very very common, not only with brother but also with fathers and mothers. Distance is the main reason why mothers don´t go to OTP after being screened. We met with 8 supervisors of approx. 15 that WV have (8 at the beginning of the meeting, 11 at the end)

- *6/11/19 visiting OTP in Hmbe. They have v*ery few admissions. We noticed the MUAC measurements are always rounded. They did not perform any passive screening. But we did one and found 3 SAM cases in 5 minutes. They have Plumpy nut because they are close to the local municipal warehouse, when they ran out they go for more.

Picture: Three mothers wait for their children to be weighted in Humbe. Fabiana on the left holds Muhadela Rafael (she leaves 3 hours away), Mónica with Johanes Julião in the center (1.5 hours away) and Maria Francisca (right) with Tutalemi Tchalos (1 hour away)

- *7/11/19: Onhama Community screening.* All mothers are from around, 1-3 km. Closest PTPA is 22km. CHWs are not good with MUAC or edema. They bring a mobile OTP but they just took the registration book and one nurse from the OTP

- *8/11/19: Visiting SC in Cahama.* Doctor not trained in IMAM so protocol not being implemented. Many defaulters

- *8/11/19 Visiting OTP in Wia* Children not being screened, 10 admissions in October in 10 min found 2 SAM and 1 MAM

Recommendations

IMAM scale up strategy and costed operational plan of action

A UNICEF´s surge staff member scheduled to arrive in 2020 should prioritise the development of a work plan to scale up CMAM but many challenges remain at field level. Such a plan should be well budgeted for and some of the following recommendations might help to organise it and define some of its specific actions.

Ultimately CMAM programs in Angola require strong advocacy activities so that the government recognise the nutritional needs of the population (especially in the southern provinces though not limited to these) and create specific policies to support such programs. UNICEF has a major role to play in this but at the moment is understaffed and the nutrition team requires more human resources, funds and technical support. Ideally a full time CMAM expert should be deployed. In the meantime the surge team should arrive as soon as possible, no later than January 2020.

The IMAM protocol

A new protocol is in place since May last year and a huge effort has been made to train doctors and nurses across the country. However this training has been conducted via theoretical lessons and clinical practice needs reinforcing, supervision and ultimately more training (see below).

Protocols are not followed and we have seen many deviations from it, especially in SC´s where inappropriate treatment of complications can lead to children´s deaths. Sharing plumpy nut is a huge concern but the problem already starts in OTP and SC: mothers receive very little or none explanations on how to feed their children and use the therapeutic products shared with them.

Community outreach

At the moment is one of the main bottlenecks identified during the BNA (see BNA report for specific recommendations). It faces many challenges especially on HR, supervision and funds. Quality of MUAC measurements need to be improved and better linkages with OTPs established. (see BNA report for specific recommendations).

One important issue is the referral of cases identified during active screenings. Due to the long distances to OTPs mothers ignore this referrals but it is difficult to know how many of the referred children reach the OTPs. With the current referral sheets it won´t be difficult to add one more column to confirm if the refer children indeed arrived and was admitted into the OTP. This will help to monitor the work of CHWs.

Community workers should be train on both MAM and SAM screenings and referrals at least once every year.

Referrals

There are very few referrals between the 4 components of the CMAM program: OTP; TSFP; SC and Community activities. Most of admissions for treatment are walk-in patients and there seems to be a lack of coordination between community activities and the other components. An effective strategy to create coordination mechanisms should be put in place

OTPs (PTPAs)

This is probably the weakest point in the CMAM program in Cunene. They are understaff, unsupplied and unsupervised. They only have one nurse in each one that is overburdened and cannot conduct passive screenings. The cleaning lady and others often support with measuring weight/height etc. Often they don´t admit SAM cases and prefer to refer them to the SC even without complication to avoid admitting them in a process that they find tedious.

Even some OTPs with more staff and good stocks don´t admit children or very few (2-3 admissions per month). Establishing a clear supervision mechanism, with reporting duties and goals will help to improve the performance of OTPs

Mobile clinics

Mobile clinics can be a temporarily solution to limited geographical coverage, however they are run by NGOs that are donor dependent. A good CMAM programs should not rely on them. At the moment the few mobile clinics in place don´t work as standalone mobile OTPs but rather by picking up a nurse from the OTP and move her to a temporary daily location. However this mobile OTPS should have their own staff, their own registers (at the moment they just borrow the register book from the closest OTP) and have standardized referral forms for static OTPs if they are not conducting activities regularly

Lengths of stay in SC

Lengths of stay in SC centres are unusually long. Children often remain hospitalised 20 days and some times more than 30 days. The reasons behind this are the lack of a well-functioning OTP system to discharge them to and the fear to relapse, unusually high in the southern regions. Though understandable, length of stay must be reducing since they are handicapping the whole program and contributing to high mortality rates.

Good reporting and monitoring of the lengths of stay by supervisors will help to improve this indicators and follow up of discharge children by CHWs could help to reduce relapses. A clear mechanism between SCs and CHW should be established; today is non-existent.

High mortality rates in SC

Mortality rates in SC remain constantly above SPHERE standards and some months higher than 25%. They are high both in municipal hospital and in more remote SC; in NGO managed hospitals and in government run ones. It is difficult to understand the reasons for these deaths. Ultimately protocols are not followed and children nor monitored regularly. Some doctors argue that most deaths occur 24 hours after admission due to late admission of cases, others that they happen during the night shifts etc. To

better understand the reason of these deaths and tackle the problem each SC should implement a study to monitor these deaths, find the causes and address them. For example if they do happen during night shifts: supervise the night staff, insist on good practices and reinforce night shifts. A brief protocol for such studies should be put in place together with data collection tools.

Performance indicators

As discussed above mortality rates remain high in SCs but defaulters is a huge concern, especially in OTP. Defaulters are not well documented. In many OTPs we could see that children who stop coming are not discharged in the register books, waiting for them to come back, even when months have passed. Reported defaulter rates remain high but real defaulter rates could be as high as 80% in many OTPs.

First, we need to ensure that reporting and measurement of defaulters is done properly and second, we need to work with CHWs to follow up defaulters. At the moment there is very little communications between OTPs and CHWs.

Picture: Antonia waits with her son Ezequiel Bautista during a standardization exercise for a SMART survey

Measuring MUAC

In general there are many deficiencies at all levels when taking MUAC measurements: from active screening in the communities to SCs. The middle point is not found, the wrong arm is measured, the tape is too tight or too loose etc… When measurements are registered rounding is a common issue and many times only registered in centimetres without decimal points.

Stocks

Stock outs of RUTF are a serious limiting factor often mention in the BNAs performed across country. Implement rapid nutrition evaluations will help to increase the capacity of service providers on planning, quantification, storage capacity and buffer stocking. Ultimately a clear costing plan for nutrition commodities need to be put in place, including transportation costs to remote health facilities since it is at the last mile that the problem is more accurate.

Commodities for MAM have been absent for the past year but now they are arriving. Without a strong WFP in country a clear strategy on how to manage MAM cases is needed.

M&E

The quality of nutritional data is very poor. Data sources and data collection tools (from surveys to patients records) need to be revised to ensure quality. Supervision is needed to ensure data collection but data analyses tools need to be put in place too to generate information products that are useful and that are disseminated widely: both at national, provincial and health facility level. A strategy for a Nutrition Information System needs to be written and costed.

Traditional medicine

This is an issue often highlighted by health staff: mothers requesting the services of traditional doctors in the first place and only going to health facilities when complications appear. However there is very little dialogue between Public health doctors and traditional doctors. Working together should be a priority and this is not something strange to CMAM programs. Many other countries with strong traditional doctors' practices have establish good referral mechanism and if managed properly these community resources could be very useful to mobilize communities, raise awareness, screen cases and facilitate treatment.

The starting point should be an anthropological study from experts with experience in these matters in different contexts.

Training of health staff

This aspect has already been explored in more detailed in the BNA report. Training should not be just a one off theoretical workshop and a new protocol but a continuous process focused on daily clinical activities. A clear training and supervision plan with MoH and partners should be developed. If expertise only exists in Luanda, ways to share it with the different provinces should be explored.

One idea is to bring the expertise from Luanda to a reference hospital in each province to create centres of excellence in collaboration with the central MoH, UNICEF and other international partners. In its turn this

centres of excellence could serve as model hospitals with SCs and OTPs that could facilitate 2-4 weeks fellowships to other health facilitate in the province and thus share good practices widely.

Oedemas

There is a clear divide between the north and south regions. Oedema cases are more prevalent in the North and in Luanda while in the south region they stay at around 10% of all SAM admissions. Given the high number of oedema in some provinces it is not practical to admit all kwashiorkor cases for inpatient treatment. This is something that should be explore and the protocol adapted accordingly, for example using oedema +, ++ and +++ to better discriminate among oedema cases.

Correction factor to estimate incidence and burden of SAM

During a webinar on "SAM Incidence Correction Factor Research Findings" that was held on 25th February 2019, a new correction factor to estimate the incidence of SAM cases for Angola of 6.4. This new correction factor has been used during 2019 for SAM burden calculations in Angola. However, after contacting UNICEF and those responsible for this research, it is clear that these new correction factors don´t receive yet enough consensuses. The current recommendation is to continue using the standard correction factor of 1.6. Thus SAM burden should be calculated as:

SAM burden (children with SAM over a year) = Population <5 X Prevalence of SAM X 2.6

Annex 1: agenda for the monitoring visit to Cunene from 3.11.2019 to 10.11.2019

Participants:

Fanceni Balde – UNICEF, Joana Fortunato – UNICEF, Carlos Lopes – UNICEF

José Morán – Especialista em GIDA

Teófilo Emilio – GPS Cunene

Armindo Sambambi – World Vision

Domingo , 3 de Novembro - 1º dia

Horário	***Actividade***	***Notas***	***Local***
16:00 -17:00	*Chegada a Ondjiva,*	*Ida para o Hotel*	*Hotel Águia Verde*

Segunda-feira , 4 de Novembro - 2º dia - Encontros institucionais e Visita de Campo as UENs

Horário	***Actividade***	***Notas***	***Local***
8:30 – 8:45	*Encontro com UNICEF Staff*	*Carlos Lopes, Manuel Eduardo e Joana Fortunato*	*UNICEF*
9:00 - 10:00	*Encontro com GPS Cunene*	*Dra Georgina Nunes, Dr. Belarmino e Teófilo Emílio*	*GPS*
10:15 – 11:30	*Encontro com Técnicos dos PTPAs e UENs*	*Teófilo Emílio e Supervisoras Municipais de Nutrição*	*GPS*
11:45 – 12:30	*Visita a UEN do Hospital Geral de Ondjiva*	*Dr. Daniel e Teófilo Emílio*	*H. Geral Ondjiva*
12:30 – 13:30	*Almoço*		
14:00 – 17:00	*Visita a UEN do Namacunde*	*Dr. e Teófilo Emílio*	*H. M. Namacunde*

Terça-feira , 5 de Outubro 3º dia – Encontros institucionais e visita aos armazéns

Horário	***Activity***	***Notes***	***Local***
8:30 – 9:30	*Reunião com os parceiros da Visão Mundial*	*Mario Ernesto, Armindo Sambambi e Isaías Canivete*	*Escritório da VM*
9:30 - 10:30	*Reunião com os supervisores dos ACS ou alguns ACS*	*Armindo Sambambi e Isaías Canivete*	*Escritório da VM*
10:45 – 11:15	*Visita ao armazém da Proteção Civil*	*Victor Júnior*	*Protecção Civil*
11:15 – 12:15	*Almoço*		
12:30 – 13:30	*Visita ao armazém do GPS Caculuvale*	*Dra Emília e Teófilo Emílio*	*Caculuvale*
13:45 – 14:45	*Visita ao armazém do GPS sede*	*Dra Emília e Teófilo Emílio*	*GPS Sede*
15:00 – 17:00	*Visita ao armazém do GPS Namacunde*	*Dra Emília e Teófilo Emílio*	*Namacunde*

Quarta-feira , 6 de Novembro 4º dia - Visita de Campo a Ombadja

Horário	***Actividade***	***Notas***	***Responsabilidade***
8:30 – 9:30	*Saída para Xangongo*	*Ver intervenções do programa de nutrição e encontro com autoridades locais*	*UNICEF*
9:30 - 10:30	*Encontro com a Administração Municipal de Ombadja e Direcção Municipal da Saúde*		*UNICEF/GPS*
10:45 – 11:15	*Visita ao armazém do município (C.S. Humbe)*	*Onde armazenam os produtos que chegam do armazém provincial, pouca capacidade e distribuição insuficiente às US*	*UNICEF/DMS*
11:45 – 13:45	*Visita a UEN do Chiulo*	*Dr. Ivo*	*UNICEF/DMS e GPS*
14:00 – 14:30	*Encontro com o CUAMM*		*UNICEF/ GPS*

Horário	***Actividade***	***Notas***	***Responsabilidade***
15:15 – 16:00	*Visita ao Safe Heaven de Omayuku*	*Verificação das actividades dos ACS e convergências das actividades de WASH, Nutrição e Educação*	*UNICEF/VM/DMS e GPS*
16:00 – 17:00	*Visita a um PTPA em Ombadja*	*Verificação das actividades dos ACS nas aldeias e discussão com comunidades*	*UNICEF/VM/DMS e GPS*

Quinta-feira , 7 de Novembro 5º dia - Vista de campo a Cahama

Hour	***Activity***	***Notes***	***Responsibility***
7:30 -9:30	*Saída para a Cahama*	*Ver intervenções do programa de nutrição e encontro com autoridades locais*	*UNICEF*
9:45 – 10:30	*Encontro com a Administração Municipal da Cahama e Direcção Municipal da Saúde*		*UNICEF/GPS*
10:45 – 12:00	*Visita a UEN da Cahama*		*UNICEF/DMS e GPS*
12:20 – 15:00	*Vista ao C.S da Uia e áreas afectadas pela seca*	*Verificação das actividades dos ACS nas aldeias e discussão com comunidades*	*UNICEF/VM*
15:00-17:00	*Regresso a Ondjiva*		*UNICEF*

Sexta -feira , 8 de Novembro 6º dia – Encontros institucionais

Horário	***Actividade***	***Notas***	***Local***
8:30- 9:00	*Encontro com a Vice-Governadora*	*Apresentação da situação nutricional na província do Cunene e resultados atingidos até o momento*	*Governo Provincial*
9:15 – 09:45	*Encontro de concertação com a VM*	*Sr Mario Ernesto*	*Escritório da VM*
10:00 – 12:00	*Encontro com GPS sobre análise de estrangulamento*	*Teófilo Emílio e José Moran verificar os dados*	*Escritório do UNICEF*

Horário	***Actividade***	***Notas***	***Local***
12:15 – 13:15	*Almoço*		
11:30 – 12:30	*Encontro com UNICEF Staff*	*Fanceni, Joana, Carlos, Manuel Eduardo*	*UNICEF*

Sábado , 9 de Novembro 7º dia – Visita de Campo ao Cuvelai

Horário	***Actividade***	***Notas***	***Responsabilidade***
7:30 - 10:30	*Saída para o Cuvelai - Calonga*	*3h30 de percurso via estrada*	*UNICEF*
10:45 – 13:45	*Visita a Comuna da Calonga e as áreas afectadas pela seca*	*Verificação das actividades dos ACS nas aldeias e discussão com comunidades**. 34% de DA Global***	*UNICEF*
14:00 – 17:00	*Regresso a Ondjiva*		

Domingo , 10 de Novembro - 8º dia - Regresso a Luanda

Horário	***Actividade***	***Notes***	***Local***
14:30 - 14:45	*Saída de Ondjiva*	*Ida para o Aeroporto*	*Hotel Águia Verde*
17:00 -18:00	*Chegada a Luanda,*		