



Final Project Report

Project Name: **ANGOLA EMERGENCY NUTRITION PROJECT**

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Country / Region: Angola, provinces of Huila, Benguela, Kuando Kubango and Namibe

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A. Summary

Life of Project Summary

The Angola Emergency Nutrition Project ended on the 2nd of February, 2015. World Vision Angola in Huila, Namibe and Kuando Kubango and Catholic Relief Services (CRS) in Benguela trained a network of 1,385 Community Health Workers (CHWs) and worked with 506 health technicians from 287 outpatient during the life of the program. A total of 50 health facilities were upgraded or received equipment. A total of 24,402 children were treated for SAM and 20,143 for MAM. A total of 277,873 caregivers received community education of feeding practices and 225,685 received messages on hygiene. A total of 32,426 households received vegetable seeds good for 97,278 months of food self-sufficiency.

The final evaluation showed that there were slight increases in exclusive breast feeding for children up to 6 months from 21.46% to 23.89% and in using foods from 4 food groups or more for children between 6 and 24 months from 33.31% to 36.95%

Overall the program met most objectives except for vegetable seed distributions. The target was to distribute seeds to 40,000 households but we could only report that 33,257 households received due to the fact that by the time of writing this report we had not yet received the beneficiary list from the department of agriculture in Kuando Kubango. The number will increase when we receive these lists.

The project worked in close collaboration with the Provincial and Municipal health departments, UNICEF, and the health technicians in the outpatient nutrition centers. In general, the CHWs worked well screening, identifying and referring malnourished children to the outpatient nutrition centers but unfortunately the provincial health departments did not allow them to treat children with SAM and MAM at the community level. This was different in the provinces of Bie, Huambo, Kwanza Sul, and Zaire where WVVA and partners were authorized to treat children through their CHW networks. In a next program this issue needs to be resolved. It is clear that after children have been identified with SAM or MAM, they need to go to a health facility for a first consultation to check their weight for height, conduct deworming, apply Vitamin A and provide other treatment that is required. However, after this the nutritional treatment could be done by CHWs at the community level. This will reduce the high default rate particularly amongst children with MAM.

Through the FFP funded Emergency Food Security Program (EFSP), therapeutic and supplementary supplies were generally available at the outpatient nutrition centers.

Nutrition and hygiene education session during community screening reached much more caregivers than anticipated. Community kitchen sessions using locally available products were very popular.

Food insecurity remains high in any of the municipalities where the project was implemented leading to high malnutrition levels. However, general feeding practices are also contributing significantly to

high levels of malnutrition. At the end of the program the SAM rate was still 4.2%, MAM 10.6% for a GAM rate of 14.8%. Levels will reduce as of May when the main harvest season starts but levels will most likely remain alarmingly high as we have experienced during the implementation of the program.

A next Nutrition program will need to address the various factors leading to malnutrition equally. Treatment to save lives is obviously needed but a stronger nutrition education component linked to vegetable gardening and the promotion of more diversified agricultural production systems is equally important.

Quarter Summary

During the reporting period October 2014 – February 2nd, 2015, WV implemented the Angola Emergency Nutrition Project in the four (4) provinces of Huila, Benguela, Kuando Kubango and Namibe in the Southern region of Angola. In the last quarter of the program there was a decrease in the number of children screened and treated due to the Christmas holidays and the slow work pace during the last month of the project; however as predicted the rates of severe and moderate malnutrition are much higher than the previous reporting period across all four provinces. This is mainly due to the fact that the hunger months usually start in November and last to May when staple crops such as maize, beans, and sorghum are harvested.

CHWs in the four provinces screened a total of 20,498 children. GAM rates vary widely by month and by location and the rate for the southern region has risen to an alarming trend this past quarter (11.2% last quarter vs 14.8% this quarter). Care must be taken in interpreting the data presented below. The potential contributing factors for the rise are: 1) low or absent food production in the region, please note that this is the peak of the hunger months, the rain started at the end of November, people have started sowing their seeds but crops wilted due to insufficient rains between the end of December and the end of January, 2) there were measles and cholera epidemics in Menongue in October, November and December, 3) the data collection was erratic due to the holidays in December and January, and 4) the scaling down of activities in January. The summary table below compares the data from the period July to September and data from October 2014 to January 2015.

Provinces	July – September 2014			October 2014 – January 2015		
	% SAM	% MAM	% GAM	% SAM	% MAM	% GAM
Benguela	2.8	8.1	10.9	4.0	8.8	11.8
Huila	2.9	8.6	11.5	5.1	11.1	16.2
Kuando Kubango	7.2	9.5	16.7	3.6	13.9	17.5
Namibe	N/A	N/A	N/A	5.6	13.1	18.7
	2.9	8.3	11.2	4.2	10.6	14.8

Please note no screening data from Namibe were available for the period July – September 2014. Screening data from Kuando Kubango is only referring to screening conducted in Menongue. Data from other municipalities was excluded due reporting problems.

The table above shows clearly that malnutrition rates have gone up significantly in the last quarter of the program. SAM rates increased from 2.9 to 4.2% and MAM rates from 8.3 to 10.6%. GAM rates increased from 11.2 to 14.8%, a 2.6% increase.

The holidays in December and January affected the screening activities as all health facilities were closed except for emergency services. This meant that there were no screening activities over a period of three weeks. The nature of a project coming to an end also influenced the community activities and the number of children screened.

During this reporting period three formal skills trainings were organized for new groups of CHWs in the municipalities of 1) Namibe, Bibala and Camucucio in Namibe province, and 2) Baia Farta, Chongoroi, Caimbambo, Bocoio in Benguela province, funded by WV's private funds. The community kitchen activities were scaled up in strategic locations with the aim of reinforcing the health education activities through practical demonstration of food preparation using locally produced and available vegetables. The Provincial Nutrition Supervisor took the lead in facilitating the community kitchen activities and trainings in Huila province.

A donor visit from USAID (Pretoria) was hosted for two weeks in November in the provinces of Huila and Benguela. Normal day-to-day activities were presented including patient screening, referrals, health education, community kitchen and government linkages. World Vision US also carried out a supervisory visit at the end of February 2015.

In February, a consultant and project staff carried out the final KAP evaluation in the provinces of Huila and Benguela. The provinces of Namibe and Kuando Kubango were not included because at the start of the project activities were only implemented in the provinces of Huila and Benguela. Work in the other two provinces started later. A summary of the key findings is presented below, while the full report accompanies this final report.

KAP Summary

The result of the rapid assessment during the KAP survey showed that global acute malnutrition (GAM) is prevalent among 664 (14.84%) out of the 4,475 children in the Huila and Benguela. At baseline global acute malnutrition (GAM) was (8%) in 187 of the 2,323 children 5-59 months screened in Huila while in Benguela, out of 2,152 children 5-59 months old, 477 (22.17%) were identified to be suffering from GAM. At project closure GAM in the both provinces of Huila, and Benguela was at 14 % (table 6). However, in Huila alone GAM was 16.2% in January 2015. Early identification through CHW and time referrals may also be one reason for the high GAM caseload recorded in Huila among other factors. Benguela, had a GAM rate of 11.8% indicating a reduction of about 10.3% compared to the baseline. There were, however, still differences between municipalities with Kuvango, Gambos and Lobito registering GAM rates of 19.1%, 17.8% and 16.6 % respectively.

Although, some localities like Cacula in Huila had cases of malnutrition reversed due to the intervention, most areas in the intervention regions still have a GAM of over 14%, a level that calls for intervention, and therefore the CMAM program is still vital as per UNICEF recommendation.

Over 277,873 beneficiaries had Behavior Change Communication (BCC) messages on nutrition and hygiene delivered to them. On closure of the program 38,020 children were treated for SAM and 24,031 (Girls-8,291 and Boys-6,238) for MAM. About 507 health care providers from MOH and 1,382 volunteers /Community Health worker (CHW) were trained in the prevention and management of SAM. A total of 50 sites have been established or re habilitated for inpatient and outpatient care.

The poverty conditions in the Benguela and Huila provinces are evident among families, showing limited sources of income, low educational attainment, poor water and sanitation facilities, lack of access to food. These factors contribute to the severity of malnutrition among children. High illiteracy limits income generating opportunities and there is an increasing number of young single mothers.

There was a positive change in the number of women who exclusively breastfeed their children until 6 months as compared to the baseline data from 21% to 24%. However, still many mothers do not practice exclusive breastfeeding up to 6 months although most continued breastfeeding their children up to 2 years of age. Additionally, despite the common opinion that breast milk is nutritious, this may not be well understood by many others still as many could not mention the benefits of breast feeding a child for the first 6 months.

The inability of parents to provide their children both the right amount and quality of food for their health needs and lack of understanding of the importance of breastfeeding, worsens the situation of malnutrition in the affected regions. Complimentary food is introduced at a very early stage and grandmothers and older children are often the main caregivers. This knowledge should influence how, when, what and who BCC messages should be delivered to.

Many parents have limitations in identifying signs of malnutrition and hence children are often already seriously malnourished when they reach the health facility. The role of Community Health Workers (CHWs) is therefore crucial in saving children's lives and to continue community education of proper feeding practices.

Due to a lack of good sanitation and hygiene practices, many children are susceptible to infections. Caregivers reported that 1 in 3 children had diarrhea in the last three months.

Lastly, food is a serious problem and many households are food and nutrition insecure due to both poor access and quality of food. This needs to be addressed with sustainable strategies to avoid chronic malnutrition among children under the age of 5. There is a scarcity of food stocks and families are food insufficient for several months during the year, mostly from November/December

through May. Farm yields are exhausted before the next harvest season. Although families are mostly engaged in farming, the gap between food supply and demand in the home is clearly a problem that requires urgent action. Seed distribution offers a possible avenue to improve nutrition and food security at the household level and could potential improve the economic situation of communities. This however needs inputs and capacity building support by the government and its partners.

Well planned CMAM can help save and change behavior but this requires long term community education programs. Behavior change messages should be embedded in all aspects of community to address, poverty, health, and gender inequality in order to reduce morbidity and mortality, and improve health and nutrition among children under 5. There is a need to further understand the underlying factors influencing childcare and feeding practices, income expenditure patterns on food in all other regions in the country. Long-term strategies are needed to address food and nutrition security as well as policies around nutrition.

Huila

The WV nutrition team assisted by the Community Health Workers carried out the screening activities at the community level however this was constrained by the shift in focus to locations like Namibe and Kuando Kubango provinces, two provinces that were lagging behind in reaching their targets. There are a total of 248 active CHWs in Huila province, who continued to carry out health education activities (including community kitchen) in their respective communities, usually done during mass screenings. The activities in Huila province focused on consolidating the gains and filling the gaps, as the project was coming to a close. The extension of funding up to the end of February 2015 has facilitated the wrapping up activities. The community kitchen activity received an additional boost during this reporting period; almost every screening session was accompanied by kitchen demonstration and mobilization of mothers for improved food preparation. It is important to note that many communities are normally steep in tradition; however it is also interesting to highlight their openness to learning new food preparation techniques.

The rains started in November and December over a period of four weeks but stopped for a period of four weeks from the end of December until late in January, almost all crops that had been planted during the start of the rains dried up due to a lack of sufficient rain. The number of malnutrition cases have dramatically increased compared to the previous quarter, this could be attributed to the seasonal hunger period around this time of the year.

Namibe

The Huila based staff continued to carry out the supervision activities in Namibe province. Three CHW training sessions were conducted in the municipalities of Namibe, Bibala and Camucuio during the reporting period using WV private funds. The malnutrition data coming from the three municipalities are showing higher but stable numbers very similar to Huila and Benguela.

Kuando Kubango

The main activities in Kuando Kubango province included the intensive supervision of the CHWs especially around the provincial capital, Menongue. It is important to note that Menongue had serious measles and cholera epidemics during the months of November and December, which contributed significantly to the increased rate of malnutrition. The initial numbers coming from Menongue have alarmed program management and the provincial authorities which necessitated a review of the data and carried out additional investigation as to the causes. Whilst the skills of the newly trained CHWs were dramatically enhanced through improved supervision, the juxtaposition of malnutrition and epidemics worsened the situation.

Benguela

In Benguela, four major activities were carried out by CRS during the October-January reporting period including; 1) in-service training of CHW supervisors, 2) screening of children at community level, 3) regular supervision visits to PTPAs and UENs, and 4) training of technicians and CHWs in Baia Farta, Chongoroi, Caimbambo, and Bocoio. The 271 trained community volunteers continued to do the screening and health education activities in their respective communities. The community screening and regular supervisory visits to the PTPAs were carried out but were limited in scope due to the nature of the activities during the last periods of the project; focus was spent more on structures and sustainability to ensure that the nutrition activities continue beyond the life of the project.

Key highlights for the program

The table below gives the overall picture of the activities and outcomes in the therapeutic feeding centers for children admitted with severe acute malnutrition in all four provinces. A total of 2,109 (October), 1,531 (November), 1,411 (December), and 1,196 (January) children were treated for malnutrition this quarter. It shows an increasing trend compared to the previous quarter (the figures are cumulative and combined for all 4 provinces).

Therapeutic Feeding Centers												
	Oct			Nov			Dec			Jan		
	New Cases	Total Treated	Discharged	New Cases	Total Treated	Discharged	New Cases	Total Treated	Discharged	New Cases	Total Treated	Discharged
KK	752	1720	643	293	620	303	77	2061	1432	813	1638	474
Huila	436	1236	368	437	1230	386	534	1311	385	361	1245	267
Benguela	773	2630	677	746	2776	685	730	2818	623	0	0	0
Namibe	148	229	44	55	122	9	70	161	0	22	68	38
TOTAL	2,109	5,815	1,732	1,531	4,748	1,383	1,411	6,351	2,440	1,196	2,951	779

Due to the poor quality of data coming from the health facilities it is recommended that a modified approach to case management is instituted in order to address the various factors affecting cure

rates of admitted patients. A total of about 6,247 malnourished children with SAM were admitted to program this quarter.

Since the start of the program 24,402 children have been treated for SAM, which is double the number of children anticipated at the program startup. This is mainly due to the fact that during program implementation WV and CRS included additional municipalities/cities in the program, including Lubango, Lobito, Benguela, and Catumbela. The number of children with SAM was very high in the densely populated areas.

The current GAM rates remain alarmingly high at over 14%. As predicted in the last quarter there was a sharp rise in the malnutrition rates most likely due to the factors mentioned above: hunger period and epidemics. To improve the quality of the data it is essential that CHWs are regularly supervised. To improve the mapping of malnutrition over a period of time (12 months period) it is highly recommended that a quarterly household based monitoring system is implemented in order to catch the oscillation in the rate of malnutrition due to the seasonality of food production. It is worth noting that the bulk of the current community data was produced by the CHWs with minimal support from project staff. This is a strong indication of the CHW's capacity to implement CMAM. However, the health care facilities and structure need to be restructured to address the multiple issues in the inpatient care system including technical skills, staff tenure, multiple treatment monitoring systems, lack of a protocol for managing MAM, lack of motivation, etc.

An additional cadre of CHWs was trained in Namibe province (a total of 138) to improve the coverage of target municipalities of Namibe, Bibala and Camucio. In addition a total of 150 CHWs were trained in Benguela province to address the lack of trained volunteers in the remaining municipalities not covered by the project, namely; Baia Farta, Bocoio, Caibambo and Chongoroi. Please note that World Vision used its private funds to finance these two sets of trainings. There are now a total of 1,382 trained CHWs, across the four provinces which the government could access and integrate in the MOH structure. The province of Huila has a unique situation because the CHWs in the 8 municipalities outside the coverage of AENP had access to a UNICEF training program.

The program anticipated to work with 400 CHWs but trained a total of 1,382 CHWs. Additional CHWs were needed in new areas where the program started working, including in Lubango, Benguela, Lobito, and Catumbela. However, the turnover among CHWs was also high due to several factors, including lack of sufficient incentives for the amount of work required and the lack of supervision by the MoH health staff. In areas where there were strong links between the health facility and the CHWs motivation was much higher.

During this reporting period, a total of 109,884 caregivers participated in health education sessions, the sessions were delivered by the CHWs using structured BCC. Topics were focused on three important issues; 1) exclusive breast feeding, 2) diversification of weaning foods, and 3) hand washing. The overall number of children and mothers targeted for this specific objective has been reached twice over since the previous reporting period. However, change of behavior takes time; perhaps

the better indicator to measure is change of attitude especially for a short term emergency project like this one.

Since the start of the program 277,873 caregivers received BCC messages on proper feeding practices and 225,685 on hygiene practices, 5 times the planned number. Messages were delivered during all the community screening sessions when mothers and other caregivers were assembled. The program used education materials approved and provided by the MoH and UNICEF and handed out pamphlets during the education sections. However, education sessions need to be improved in order to change people's behaviors. Groups need to be smaller and education sessions need to be more frequent, treating one topic each at the time.

During the 1st Quarter of FY15, WV finalized the vegetable seed distributions, field visits, and trainings. Due to the fatal accident of the WV extensionist in Kuando Kubango, seeds were delivered to the Ministry of Agriculture for distribution. Unfortunately by the time of writing this report the Ministry had not yet provided all the beneficiary lists and reports. Hence, we have not included the data in this report. WV is still working with the MoA of Kuando Kubango to provide the beneficiary lists so that we can complete the documentation.

The following three tables show the number of families receiving vegetable seeds, the number of people trained and the number of field visits by the WV extensionists.

		Number of Families receiving vegetable seeds					
Provinces	Sex	2nd Quarter FY14	3rd Quarter FY14	4th Quarter FY14	1 st Quarter F15 (until Jan 2015)	Total for project	Comments
Huila	Female		2,740	5,396	1,846	9,982	All target beneficiaries reached
	Male		2,632	4,917	2,469	10,018	
	Total		5,372	10,313	4,315	20,000	
Namibe	Female		1,078	1,868	2,259	5,205	All target beneficiaries reached
	Male		668	1,778	2,349	4,795	
	Total		1,746	3,646	4,608	10,000	
Kuando Kubango	Female	831	400	300	582	2,113	In June WV's extensionist had a fatal car accident and distributions stopped. Seed was given to the MoA agriculture for distribution but we did not receive the beneficiary lists yet.
	Male	270	400	225	249	1,144	
					6,743		Seeds given to the MoA for distribution based on distribution lists provided by the MoA but not yet supported by signed beneficiary lists. A total of 6,743 beneficiaries were selected by the MoA
	Total	1,101	800	525	831	3,257	
GRAND TOTAL		1,101	7,918	14,484	9,754	33,257	

Number of families receiving training in agricultural techniques							
Provinces	Sex	2nd Quarter FY14	3rd Quarter FY14	4th Quarter FY14	1 st Quarter F15 (until Jan 2015)	Total for Project	Comments
Huila	Female		1,153	1,026	513	2,692	
	Male		838	1,203	867	2,908	
	Total		1,991	2,229	1,380	5,600	
Namibe	Female		830	517	198	1,545	
	Male		505	349	86	940	
	Total		1,335	866	284	2,485	
Kuando Kubango	Female	312	0			312	Data for the 3 rd quarter are not available because of the fatal accident of the WV extensionist
	Male	111	0			111	
	Total	423	0	0	0	423	
GRAND TOTAL		423	3,326	3,095	1,664	8,508	

Number of field visits by WV extensionists (training and monitoring visits)							
Provinces		2nd Quarter FY14	3rd Quarter FY14	4th Quarter FY14	1 st Quarter F15 (until Jan 2015)	Total for FY14	Comments
		Jan – March	April - June	July – August			
Huila	# of visits		96	23	13	132	
	# of trainings		116	22	8	146	
	Total		212	45	21	278	
Namibe	# of visits		37	28	14	79	
	# of trainings		9	20	4	33	
	Total		46	48	18	112	
Kuando Kubango	# of visits	11				11	Data for the 3 rd quarter are not available because of the fatal accident of the WV extensionist
	# of trainings	13				13	
	Total	24				24	
GRAND TOTAL		24	258	93	39	414	

Over the life of the program 33,257 households received seeds out of the 40,000 planned. WVA cannot yet account for 6,743 households in Kuando Kubango due to the fact that beneficiary lists have not yet been received from the provincial agricultural department. Seeds were given to the MoA based on planned beneficiary lists prepared by the Ministry. WVA continues to work with the Department to receive the complete lists. Vegetable gardening has been well accepted by the households participating in the program. Many areas do not have a culture of producing vegetables and hence there is a lack of vitamins in people’s diets and particularly in children’s diets. Future nutrition interventions will require a strong component on vegetable gardening and nutrition education, not only at the community level but also at schools, youth clubs, and churches.

B. Challenges, Lessons Learned

Project Output	Challenges
Output 1: Improved functioning in-patient care for SAM cases aged 6-59 months.	<ol style="list-style-type: none"> 1) Skills of technical staff in the health facilities are still insufficient; they require additional training and consistent supervision. 2) Technical staff are overworked, normally there are only two nurses in each facility, and they have multiple responsibilities like reproductive health, MCH, EPI, consultation and case management, nutrition, etc. 3) Frequent change in personnel and their replacements don’t have the requisite training in nutrition. 4) Many staff in the health posts are casual workers and have no fixed tenure with the MoH, therefore they don’t take on responsibility as regular tenured staff would. 5) The registration and monitoring system of malnutrition cases is very complex and unnecessary. Some health post staff have refused to fill out forms because it takes too much time, worse in some cases they refuse to handle malnutrition cases because of work overload. 6) The government has no strategy/protocol (and system) to manage MAM, forms are not filled out and cases often not reported. 7) There are a lot of defaults particularly among MAM cases due to the fact that mothers do not consider their MAM children really sick and the fact that they only get 7 packages of plumpy sup per week. Defaulters are also due to inconsistent supervision, in some cases the lack of consistent supplies (RUTF/RUSF), lack of efficient linkages with between the CHWs and the health posts, and lack of incentives for CHWs. 8) The lack of sufficient training for health staff can leads sometimes to the substitution of products; RUTF with RUSF and vice versa. Monitoring of the FFP project shows a high percentage of patients receiving the correct dosage, but further improvements should be made. Health staff are not

	equipped to analyze the data before they are sent to the municipal health department and onwards to the provincial health department. This leads to lack of appropriate and timely response to emerging problems.
Output 2: Children with SAM without complications treated by CHWs	This particular activity was never implemented due to the reluctance of the Provincial Health departments to have CHWs treating SAM in the community. In other provinces such as Huambo, Bie, Kwanza Sul, and Zaire the treatment of children with SAM without complications was almost exclusively done by CHWs.
Output 3: Strengthened community capacity for community mobilization, treatment and referral.	<ol style="list-style-type: none"> 1) There was insufficient community mapping to adequately identify the target areas, health facility structures, personnel and CHWs. 2) The CHW selection process was in some cases flawed; in some areas the sobas carried out the selection, whilst in others they were simply selected from existing groups of volunteers. It is necessary to involve all relevant parties in the community to ensure sustainability. 3) The training curriculum is insufficient, there is a need for a revision of the content and the use of an appropriate methodology in training semi-literate adults, more time should be spent on practical methods, using local language. 4) The supervision of CHWs can be improved and stronger linkages between health facilities and CHWs need to be established. 5) Incentives for CHWs are insufficient for the amount of work they are required to do.
Output 4: Improved IYCF practices	Materials and the methodology of delivery of IYCF training need to be improved. CHWs have only one day of training on CMAM, therefore the training on IYCF was superficial.
Output 5: Increased availability of high nutritional value vegetables.	Integration of the nutrition and agriculture activities can be improved so that target groups are the same.

C. Indicator Tracking Table

Sector: Nutrition

Sector Objective: To provide nutritional education, emergency nutrition and lifesaving care for severely acute malnourished children in affected areas in Angola.

Indicators:

Indicators		Program Target	Achieved this Quarter	Achieved Cumulatively	Comments
Sub Sector: Management of Severe Acute Malnutrition (SAM)					
OFDA Indicator 1:	Number of health care providers and volunteers trained in the prevention and management of SAM, disaggregated by sex and age*	160 health technicians and 400 community workers.	80 health technicians and 288 CHW	507 health technician 1,382 CHWs	Training was carried out in 4 municipalities (Baia Farta, Chongoroi, Caimbambo, Bocoio) in Benguela province and 3 municipalities in Namibe province. The 4 municipalities in Benguela are not included in the AENP. Funding was provided by WV private funds.
OFDA Indicator 2:	Number of sites established/rehabilitated for inpatient and outpatient care.	12	UEN (In-Patient Nutrition Centers) – 3	Health facilities – 50	The UENs required the purchase of equipment, supplies and materials. Three UENs (Humpata, Kuvango and Lubango) were rehabilitated using WV private funds for a total of 50 health facilities fully operational
OFDA Indicator 3:	Number of people treated for SAM, disaggregated by sex and age*	12,261	6,247	24,402 Estimated number of boys and girls with SAM Boys: 10,981	The government reporting format does not disaggregate the patients by age but experience with screening shows that for SAM an average of

				Girls: 13,421	45% of the cases are boys and 55% are girls as presented in the previous column
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OFDA Indicator 4:	Rates of admission, default, death, cure, relapse, non-responsive transfer and length of stay.				<p>Health facility information at the provincial level was incomplete because not all health posts submitted their reports to the municipal health departments, which then submit to the Provincial Health Department. WV depended on that information as there was not enough staff to review all the health facility reports.</p> <p>WVA suggests a redesign of future programs to improve the in-patient health care structure (training, staffing, monitoring and reporting) to capture quality information from these facilities. The current data is not reliable for intelligent interpretation.</p>
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Sub Sector: Management of Moderate Acute Malnutrition (MAM)

OFDA Indicator 1:	Number of sites managing MAM		Benguela – 77 Huila – 106 Kuando Kubango – 32 Namibe – 72 Total -283	287	The number of facilities was increased by 4 in Benguela, following the training of technicians in the 4 municipalities (Bocoio, Baia Farta, Caimbambo, Chongoroi).
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OFDA Indicator 2:	Number of people admitted to MAM services disaggregated by sex and age*			<p>A total of 3,879 children were treated for MAM until the end of March 2014. As of April 2014 until the end of January 2015 an additional 16,264 children were treated for MAM with supplies from USAID/FFP</p> <p>Total Number of Children treated for MAM: 20,143</p> <p>Boys: 8,057 Girls: 12,086</p>	<p>As indicated in other parts of the report, MAM cases are not included in the government reporting system. Figures in the previous column is data collected from the FFP funded Emergency Malnutrition program data base from April 2014 plus the data that was collected by AENP until the end of March 2014 (see Quarter 2 report for FY14. The children treated with supplies from FFP were children identified by CHWs and health facilities under the AENP project.</p> <p>Screenings show that on average 40% of the MAM cases are boys and 60% are girls. The previous column shows the estimated numbers</p>
OFDA Indicator 3:	Number of health care providers and volunteers trained in the prevention and management of MAM, disaggregated by sex	160 health providers 400 Volunteers	Health Technicians - 80 CHW - 288	507 health technician 1,382 CHWs	Trained technicians and CHW have increased following the training carried in four municipalities in Benguela and 3 in Namibe, funded by WV private funds.

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Sub Sector: Infant and Young Child Feeding and Behavior Change

OFDA Indicator 1:	Number and percentage of infants 0-<6 months who are exclusively breastfed.		N=544 (21.46%)	23.89%	The final KAP survey report showed a slight increase of 2.43% in the number of mothers engaging in exclusive breastfeeding --- 134 mothers out of 565
OFDA Indicator 2:	Number and percentage of children 6 –<24 months of age who receive foods daily from 4 or more food groups (to achieve minimum dietary diversity)		N= 844, (33.31%)	36.95%	425 out of 1,150 mother reported giving their children between 6 – 24 months of age foods from 4 or more food groups

OFDA Indicator 3:	Number of people receiving behavior change interventions, disaggregated by sex and age*	54,000	109,884	277,873	All participants received training in nutrition and hygiene, topics are not disaggregated.
WV Indicator 1:	Number of people receiving direct hygiene promotion	40,000	109,884	225,685	All participants during the last quarter received training in nutrition and hygiene, topics and numbers are not disaggregated. During the last quarter there was

					no separate training in hygiene (it was included in the nutrition training)
WV Indicator 2:	Projected increase in number of months of food self-sufficiency due to distributed seed for beneficiary households	40,000 (including Cunene 25,000 now being done in Huila and Namibe) 15, Huila, 15 KK, 10,000, Namibe	Families who received seeds during the quarter: Female headed: 4,687 Male Headed: 5,067 Total: 9,764 Months of self-sufficiency after harvest of all three vegetable varieties: 3 months per family = 29,262 months total	Cumulative of families who received seeds so far: Female headed: 17,300 Male Headed: 15,867 Total: 33,257 Months of self-sufficiency after harvest of all three vegetable varieties: 3 months per family = 99,771 months total	

WV Indicator 3:	Number of people benefitting from agricultural inputs disaggregated by sex	40,000 (including Cunene 25,000 now being done in Huila and Namibe) 15, Huila, 15 KK, 10,000, Namibe,	Families who received seeds during the quarter: Female headed: 4,687 Male Headed: 5,067 Total: 9,764 Number of families trained in agricultural techniques Female headed: 711 Male Headed: 953 Total: 1,664	Cumulative of families who received seeds so far: Female headed: 17,300 Male Headed: 15,867 Total: 33,257 Number of families trained in agricultural techniques Female headed: 4,549 Male Headed: 3,959 Total: 8,508	
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* (0-11 months, 1-4 years, 5-14 years, 15-49 years, 50-60 years, 60+ years)

Annex 1: Success Story



AENP Success
Story.docx

Annex 2: Project Photos



Huila: Dr. Hector Jalipa explains the nutritional importance of a diversified diet.



Huila: A CHW talking through the UNICEF pamphlet at a community screening



A Farmer Field School in Hoque, Huila



Planted potatoes at the Hoque Farmer Field School