



REPUBLIC OF ANGOLA  
Ministry of Health  
National Directorate of Public Health

*Investing in Human  
Development*

# STRATEGIC PLAN FOR THE ACCELERATED REDUCTION OF MATERNAL AND CHILD MORTALITY IN ANGOLA

2004 – 2008

*“Effective contribution to interrupt the  
transmission of poverty from one  
generation to the next”*

Luanda, April 2004



**STRATEGIC PLAN FOR THE ACCELERATED  
REDUCTION OF MATERNAL AND CHILD  
MORTALITY IN ANGOLA**

**2004 – 2008**



# ***C o n t e n t s***

Abbreviations and acronyms	3
<b>1.</b> Executive summary	5
<b>2.</b> Introduction	6
<b>3.</b> Objectives	8
<b>4.</b> Objective 1: Reduce child mortality by 50%	9
<b>5.</b> Objective 2: Reduce malnutrition by 30%	16
<b>6.</b> Objective 3: Reduce maternal mortality by 30%	22
<b>7.</b> The health service network	27
<b>8.</b> Essential package of interventions	29
<b>9.</b> Strategies for expanding coverage	32
<b>10.</b> Strategy for improving the quality of care	34
<b>11.</b> Monitoring and evaluation	35
<b>12.</b> Organisation	37
<b>13.</b> Partnerships and coordination mechanisms	38



## **Executive Summary**

*The Republic of Angola recently emerged from almost three decades of civil war which had a serious negative impact on national development and on the health and nutrition of the population, particularly children and women. The rate of mortality among children under the age of 5, estimated at 250 deaths for every 1,000 live births, is the third highest in the world, and means that about 181,000 children die every year. Chronic malnutrition affects 45% of under-fives, and is regarded as an associated cause of death in 2 out of 3 deaths in this age group. The maternal mortality rate is also one of the highest in the world, estimated at 1,280 deaths for every 100,000 live births. This is about 11,000 maternal deaths and 36,000 orphans every year. These deaths are concentrated in poor and densely populated urban areas and in rural areas without access to health services.*

*This dramatic situation, unacceptable to human dignity, requires urgent and effective responses on the part of the government and of the entire nation, as well as of the international community, because it brings damaging consequences for Angolan society and national development. Furthermore, the first years of children's lives are the stage that offers the best opportunities for investment in human capital with virtually certain returns in terms of school achievement and economic productivity.*

*The main direct causes of the high child death rate are a small number of diseases, namely malaria, acute respiratory infections, acute diarrhoeal diseases, measles and neo-natal tetanus. These diseases are relatively easy to prevent or to treat at the level of primary health care services, and through better practices and care among households.*

*The impact objectives of the plan for the 2004-2008 period are: to reduce by 50% the mortality rate among children under 5 years old; to reduce by 30% the rate of malnutrition among children under 5, and reduce by 30% the maternal mortality rate..*

*The main constraint on reducing maternal and infant mortality is the poor level of public access to the network of services, estimated at only 30-40% of the population, due particularly to destruction by the war of many of the few infrastructures, the scarcity of staff, particularly medical staff, and geographical, economic and cultural barriers.*

*To speed up reduction in mortality, the main strategy is the implementation on a national scale of the "essential package of mother and child health care and services", which is easy to apply, low cost, and highly effective. It will be offered, seeking universal coverage, in three ways: (1) the fixed network of public health, NGO and church health services; (2) advance and mobile health teams to care for vulnerable groups who have no access to health services, and (3) community and household based activities.*

*Implementation of the plan will seek to strengthen the technical and management capacities at provincial and municipal levels, and will promote innovative initiatives making it possible to overcome the main constraints for each of the three forms of supplying the care package. Indicators will be defined that make it possible to monitor progress and constraints in order to take corrective action, to increase availability, use and effective coverage in the package interventions.*

*The Ministry of Health will promote wide-ranging partnerships with cooperation bodies and civil society in order to obtain support, mobilise resources, increase national capacity, and strengthen health activities in a sustainable manner. The roles of each of the partners will be defined in an agreed way, considering their mandates and potential, seeking coordinated, complementary and synergetic support for the benefit of the neediest population groups.*

*With the consolidation of peace and national reconciliation, the strengthening of institutional capacity and the extension of state administration throughout the country, there are unprecedented opportunities to undertake initiatives that seek to solve national problems, and achieve national and international development targets.*

## 2 Introduction

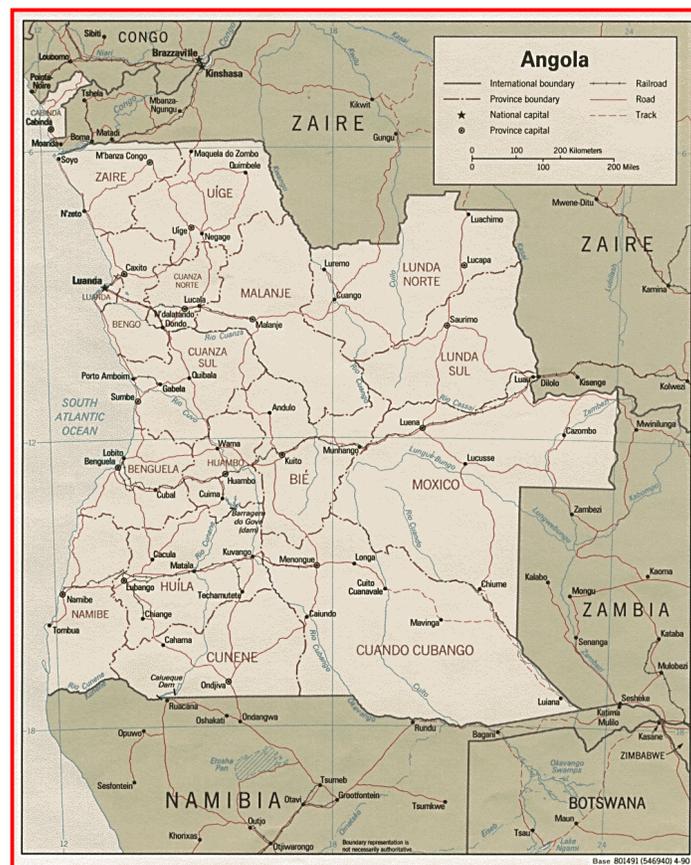
*The country recently attained peace and is now seeking the transition the transition from emergency to wide-ranging and sustainable economic and social development. The human and health development indicators indicate one of the most dramatic situations in sub-Saharan Africa, and they demand urgent and effective responses.*

### Context:

The Republic of Angola is located in the west coast of Africa. It is one of the largest countries of the continent with a surface area of 1.2 million km<sup>2</sup>. Its growing population is estimated at between 14 and 17 million inhabitants, of whom about 60% are less than 18 years old.

Life expectancy at birth is 40 years, one of the lowest in the world. The total fertility rate is very high, at 7.2 children per woman. The country is multicultural and multi-linguistic. More than 18 national languages are spoken, and modernity and ancestral ways of life coexist. Politically and administratively, Angola is divided into 18 provinces, 164 municipalities and 557 communes.

According to the Human Development Index, the country is in 162<sup>nd</sup> place, out of a ranking of



173 countries. The incidence of poverty<sup>1</sup> is 68 per cent of the population, of whom 28% live in a situation of extreme poverty.

The post-conflict framework shows feeble food security, an unhealthy urban environment, increased exposure to infectious disease, roads in a bad state, destruction of many of the bridges and health infrastructures, and lack of access of broad strata of the population, particularly in the countryside, to primary health care.

<sup>1</sup> INE. Household survey on expenditure and income. 2000-2001

## Justification:

During the first three years of a child's life, the cerebral connections multiply, and the motor that will drive reasoning and behaviour patterns is formed. The first years of life are the most critical stage in the development of a child, and this is the period that offers the best opportunities for protecting human capital.

Investing in children and their mothers is the most effective contribution towards interrupting the transfer of poverty from one generation to the next.

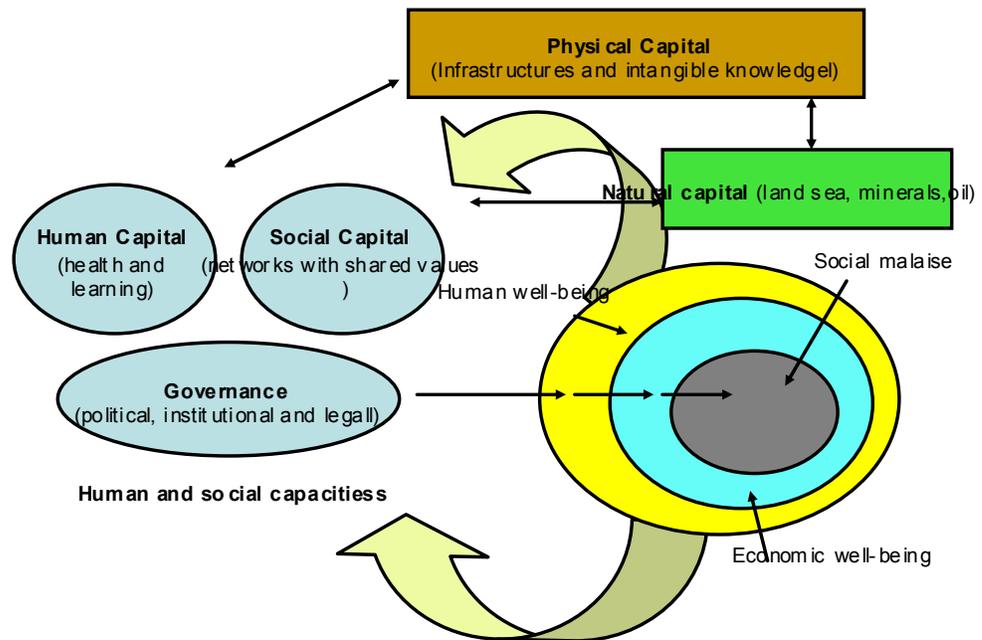
Society must create the conditions and facilitate the resources to guarantee the survival and psychomotor development of children and prevent maternal deaths. Health care and nutrition during pregnancy and infancy are extremely critical, and will have effects that last throughout life.

The main reasons why society should invest in the survival and development of children and their mothers, that is, investing in the development of human capital, are:

1. To preserve the right to life of children and women, and to give them the best possible conditions for their human development;
2. To guarantee returns; greater school achievement, and economic productivity;
3. To improve the individual skills of human resources and thus the country's ability to compete in a globalised economy;
4. To reduce social and economic disparities.

The following graph shows the importance of investing in human capital for the economic and social development and well-being of the nation.

**Figure 1: Relations between human capital and socio-economic development**



**3****Objectives*****Purpose:***

To contribute to improving the health and reducing the poverty of the Angolan population, particularly of the most vulnerable groups, children and women.

***General objectives:***

The following general objectives will be achieved at national level in the 2004 -2008 period:

1. Reduce by 50% the mortality rate among children under 5 years old (from 250 to 125 deaths per 1,000 live births).
2. Reduce by 30% the rate of malnutrition among children under 5 years old (from 31% to 22% malnourished as measured by weight/age).
3. Reduce by 30% the rate of maternal mortality (from 1,380 to 970 deaths per 100,000 live births)

***Specific Objectives:***

1. Increase access, and improve the quality of primary health care services.
2. Promote community based health activities, seeking the involvement of households in health demand and care.
3. Improve the reference system, and the quality of essential obstetric and paediatric services.
4. Improve the system of health information, monitoring and evaluation.
5. Ensure continual availability of vaccines, essential medicines, reagents, and critical materials at national, provincial and local level.
6. Expand preventive activities, and the coverage of the standardised and correct diagnosis and treatment of malaria and HIV/AIDS.

# 4

## Objetivo 1:

### Reduce by 50% mortality among children

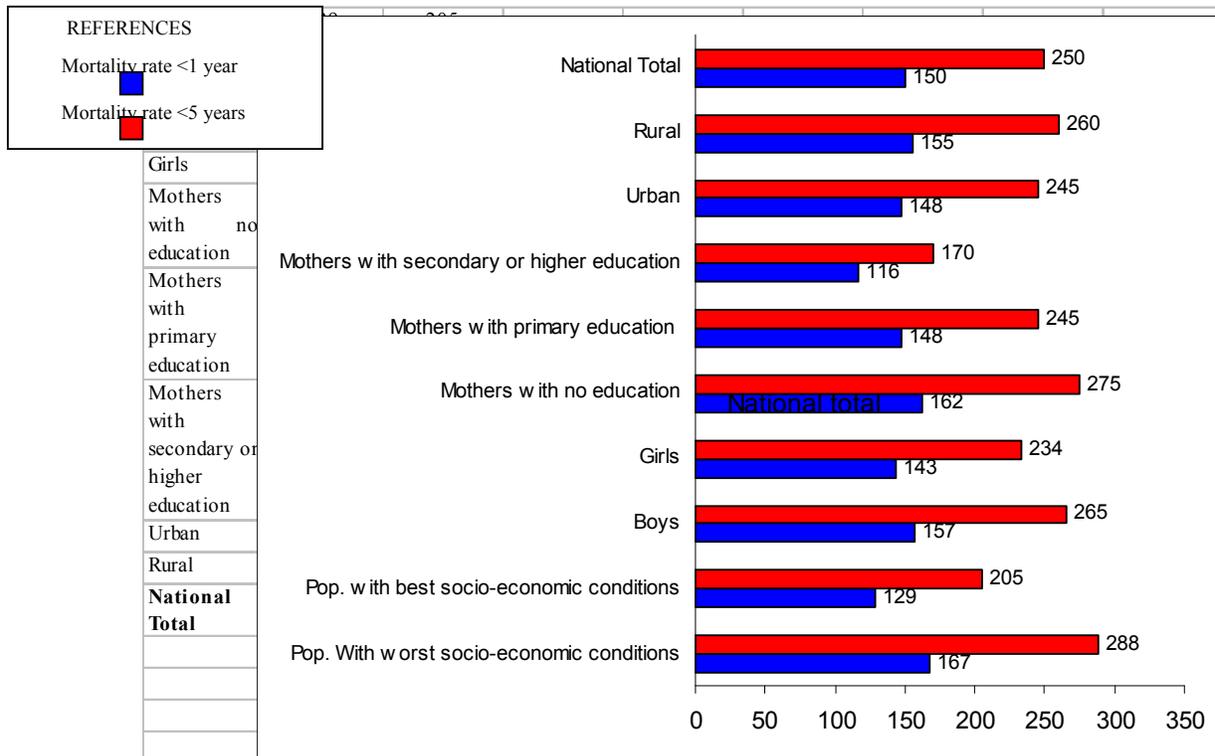
The mortality rate among children under 5 years old in Angola is estimated at 250 deaths per 1,000 live births<sup>2</sup>, that is, one out of every four children die before their fifth birthday. This is the third highest child death rate in the world, and almost double the average rate for sub-Saharan Africa. The deaths are concentrated in poor and densely populated urban areas and in rural areas with no access to health services. This human tragedy means the death of about 181,000 children a year<sup>3</sup>.

#### Analysis of the situation:

The infant mortality rate TMI (death of children under one year old), and under five mortality rate, TMM5, which includes the previous rate, are the main indicators used to measure the health and well-being of children.

These indicators are sensitive to changes in the health situation, but are also the final result of a series of factors such as access to health services, water, means of excreta disposal, personal and food hygiene, food security, housing conditions, household income, and health care knowledge and practices in communities and households, for which the indicator reflects faithfully the state of health of children and the level of development of society.

**Graph N°2: ANGOLA: rates of child and under-five mortality per 1,000 live births, according to general variables, 2001**



Source: National Statistics Institute-UNICEF. Multiple Indicators Survey MICS. 2001.

<sup>2</sup> National Statistics Institute-UNICEF. Multiple Indicators Surveys MICS. 2001.

<sup>3</sup> UNICEF-State of the World's Children 2004. Basic Indicators

The level of education attained by the mother is the characteristic that provides the greatest risk differential in infant and under-five mortality, followed by the socio-economic situation. As in other countries, boys under the age of one are at greater risk of death, and in Angola this situation extends to the age of 5.

One of the particular characteristics of child mortality in Angola is that the mortality rates for urban and rural areas are almost the same, unlike other countries where the mortality rates in rural areas are considerably higher than in urban ones. This situation may be explained in part by the major displacements of the rural population into the towns due to the war, by the lack of access of the people living on urban peripheries to health care, the low quality of services, and the added environmental risks.

The fact that the MICs survey did not take into account rural populations who at this time were inaccessible because of the war does not fully explain the situation, since the estimated population of the areas was less than 5% of the country's total population. Although at the level of these provinces, particularly in the east, this omission could be significant, so that mortality may be higher than estimated.

In order to analyse mortality by geographical scope, the MICs 2001 survey grouped the provinces into regions, finding that the levels of mortality for the various regions are extremely high. The Western region stands out which has 26% more additional risk of death than the national average.

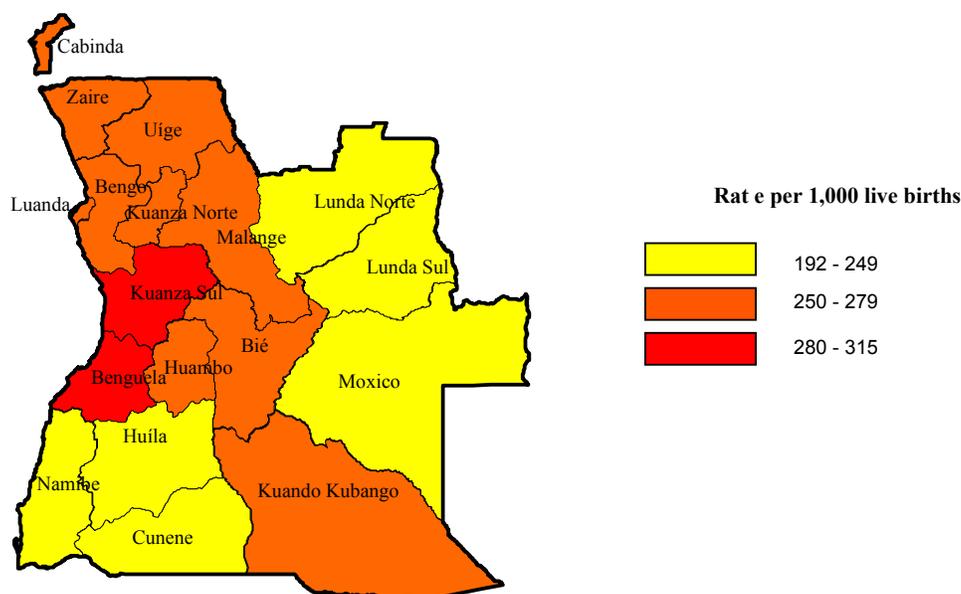
**Table N°1: Mortality rates among children under 5, and the absolute number of deaths of under fives estimated by region, Angola 2001**

REGION	TMM5	Estimated deaths	% of deaths
<b>Capital:</b> Luanda, Bengo, Kuanza Norte and Cabinda.	250	56,000	31
<b>West:</b> Benguela and Kuanza Sul	315	47,000	26
<b>Centre-South</b> Huambo, Bié and Kuando Kubango	277	29,000	16
<b>North:</b> Zaire, Uíge and Malange.	262	20,000	11
<b>South:</b> Huila, Namibe, Cunene	192	17,000	9
<b>East:</b> Lunda Norte, Lunda Sul and Moxico.	217	12,000	6
<b>TOTAL</b>	<b>250</b>	<b>181,000</b>	<b>100</b>

Source: National Statistics Institute-UNICEF. Multiple Indicators Survey MICS. 2001

The absolute number of deaths estimated is strongly influenced by the size of the population of each region: the capital and western regions concentrate more than half of the annual deaths estimated for the entire country.

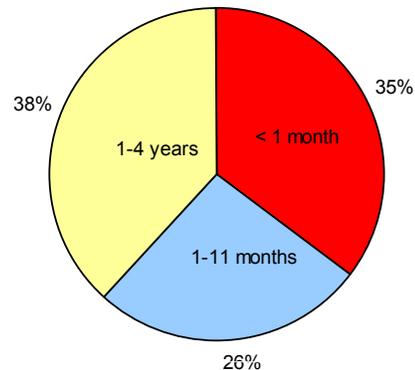
**Graph N°3: ANGOLA: Rates of mortality among children under five years old by province**



According to the data of 48,487 deaths registered in the Luanda cemeteries<sup>4</sup> in 2001-2003, 55% of them were of children aged under 5, which gives some idea of the enormous magnitude of child deaths in the general context of Angolan mortality.

Among the deaths of under fives, a third were neonatal deaths (35%), almost another third (26%) were post-neonatal deaths (1-11 months) and the remaining third (38%) took place along children 1-4 years old. This profile shows that environmental causes are more important than biological causes in determining the mortality of Angola children.

**Graph N° 4: Age structure of mortality among under fives. Luanda 2001**



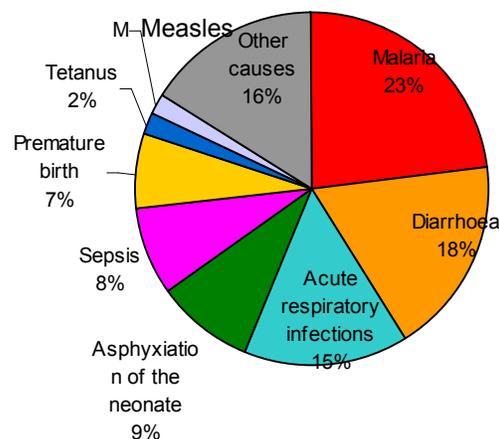
Source: Ministry of Health. Studies, Planning and Statistics Office, Deaths in Luanda Cemeteries.2002-2003

Due to the lack of vital statistics, in order to analyse the structure of causes of death among children under the age of five, information was used from 48,487 death certificates from Luanda cemeteries, for the period 2001-2003. These data were processed, using the international classification of disease, by the MINSA statistics department. But this information should be considered merely indicative of the main causes of death due to the limitations of its origin.

A small number of diseases, namely malaria, acute diarrhoeal diseases, acute respiratory infections, measles and neonatal tetanus, are directly responsible for 60% of child deaths, despite the fact that it is relatively easy to prevent or treat these problems at the level of the primary health care services, and through better practices and care at household level. Malnutrition is the main associated cause of mortality.

Despite its growing importance, AIDS does not show up in this structure, possibly due to lack of diagnosis.

**Graph N° 5: Possible causes of under 5 mortality. Luanda 2001**



<sup>4</sup> Ministry of Health -Angola. Studies, Planning and Statistics Office. Deaths in Luanda cemeteries.2002-2003.

## **Malaria**

In Angola malaria is the greatest public health problem and the first cause of morbidity and mortality in under fives. It is endemic throughout the country: it is hyper-endemic in the north and in the lowlands of the Atlantic coast, and the incidence is lower in the highlands of the centre and south of the country. Major population movements and bad housing conditions have added to malaria transmission.

The main vector is *Anopheles gambiae* which is characterised by its high vector capacity and its preference for biting humans. Annually, across the country, 1.4 to 2 million cases are reported. In 2002, 66% of the cases notified happened among children under 5 years of age. The most serious cases of the disease occur mainly in children and pregnant women. In the health network anti-malaria treatment is not always available, and is not standardised in all health units. Furthermore, there is a high level of self-medication among the public, which partly explains the high levels of resistance to the anti-malarial drugs in use.

There is still no culture among the public of using mosquito nets, even though important promotion and education campaigns have taken place. Mosquito nets treated with insecticide were introduced as a public health intervention 4 years ago. MICS-2001 found that nationally 10% of children under 5 slept under a mosquito net on the night before the research, but only 2% slept under a mosquito net treated with insecticide. The current use of treated mosquito nets is estimated at 5 to 6%.

## **Acute Diarrhoeal Diseases (DDAs)**

Acute diarrhoeal diseases are the second cause of death among Angolan children, and the second cause of consultations. The diarrhoeas reflect; deficiencies in home supply of drinking water, poor hygiene practices, lack of sanitary means for excreta disposal, and deficiencies in breast-feeding practices. According to MICs 2001 there are 6-7 episodes of diarrhoea per child per year. The highest levels of prevalence of diarrhoeas are among children aged 6 to 23 months. The rate of use of Oral Rehydration Therapy (ORT) is very low; the proportion of children under five with diarrhoea who received extra liquids and continued with feeding during the episode was only 14%. Of the breastfeeding children, only 51% continued taking their mothers' milk during the diarrhoeal episode.

## **Acute Respiratory Infections (IRAs)**

After malaria and diarrhoea, acute respiratory infections (IRAs) are one of the main causes of death among under fives, and of consultations in the country's health units. The IRAs affect equally people living in urban and rural areas. According to MICs 2001, Angolan children have an average of 4 episodes per year, but only half of these were attended to by health workers. The main cause of death is pneumonia which is more frequent and serious in malnourished children. Pneumonia develops very rapidly, and requires urgent attention. The syndrome diagnosis and standardised treatment of pneumonia are still not sufficiently implemented in the health units.

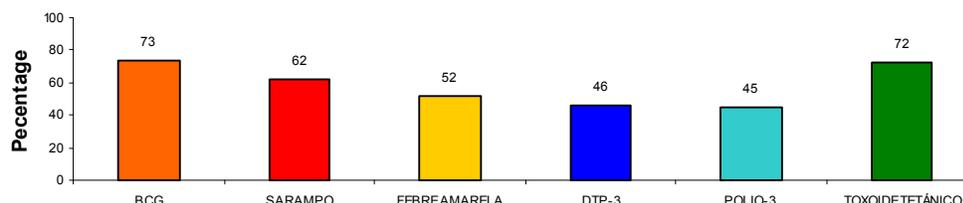
## **Diseases preventable by vaccination**

Through the Expanded Vaccination Programme (PAV), MINSA has made important advances in the last 5 years in vigilance and control of diseases that can be prevented by vaccination. Despite the difficulties of access caused by the war, it achieved broad adherence from the authorities, local leaders and community volunteers to attain coverage rates in excess of 90% during the National Days of Vaccination (JNVs) against Poliomyelitis. At the same time, a system was developed of active vigilance against flaccid paralysis, which contributed towards the elimination of the circulation of the wild polio virus from the country three years ago. Making use of the logistics of the JNVs, vitamin A was given annually to children aged between 6 and 59 months.

With the purpose of speeding up the reduction in mortality caused by measles, and based on the results of the anti-polio campaigns, in the second quarter of 2003 MINSA undertook a national campaign against measles for children aged between 9 months and 15 years. In this campaign 7.3 million children were vaccinated across the country, thus reaching a coverage rate of 96%. Taking advantage of the vaccination, vitamin A was administered. The impact of the vaccination campaign on the incidence of cases and of deaths from measles was great. The number of suspected cases notified fell from 10,350 in 2002 to 1,196 in 2003.

The coverage of routine vaccination for the separate antigens of the PAV is still low, especially for those that require multiple doses. This low coverage largely reflects the low national coverage of health infrastructures, particularly in rural areas. On the other hand, it also reflects the scant demand for vaccination by the public, the sparse activity of advanced and mobile teams attending to communities without health services, and the loss of vaccination opportunities for children and women of the target groups who visit the health units. The logistical deficiencies in the supply of vaccines, vitamin A and vaccination materials, and failings in the operation of the cold chain, make a significant contribution to the low coverage.

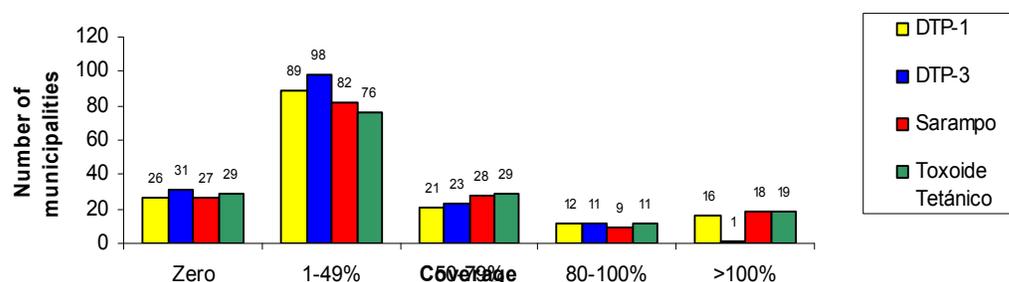
**Graph N° 6:** ANGOLA: Coverage of routine vaccination among children under one year old and pregnant women. 2003



Source: Ministry of Health. Immunisation section. 2003

In 2003 there were no routine vaccination activities in 16% of the country's municipalities (26/164 municipalities), 54% (89 municipalities) had coverage rates of under 50%, 13% of the municipalities had coverage rates of between 50 and 79% (21 municipalities), 7% had coverage of 80-100% (12 municipalities) and 10% had coverage rates of over 100% (16 municipalities). This final group reflects an underestimation of the population of these municipalities; for this reason, the target populations for municipalities throughout the country were adjusted for 2004, based on the national vaccination campaigns against polio and measles which attained high coverage rates.

**Graph N° 7:** ANGOLA: Number of municipalities by routine vaccination coverage rates. 2003



Source: Ministry of Health, Immunisation Section. 2003

### Integrated Care for Childhood Diseases (AIDI)

The strategy of integrated care for childhood diseases is not very well developed in Angola. In August 2000 the Angolan Government signed the pledge to adhere to the strategy; as from then, the training manuals were updated and adapted and a nucleus of trainers was formed. Currently the programme has 100 trained health professionals, of whom 30% can take on training functions in order to expand the strategy at national level. The main cause of slow implementation was insufficient financial resources.

## Strategic Approach:

Although the role of basic causes such as poverty, low level of education, and precarious environmental conditions is clear in determining the high mortality of Angolan children, the reduction of these risk factors is part of the national development process and cannot be modified in the short term.

Public health interventions aimed at the immediate causes of death can be implemented in an integrated way, mainly by the health sector, obtaining results in the short and medium terms, if high coverage rates are achieved and maintained in a sustainable way in effective primary health care interventions on children and their mothers.

These interventions will be preventive, reducing the risk of exposure to infection or to a condition identified as an immediate cause of death, or curative to avoid death and limit incapacity.

The criteria for selecting the interventions take into account scientific evidence of the effectiveness of the measures in reducing mortality, and the viability of the interventions to be implemented in the country, attaining high population coverage rates that are sustainable in the long term.

The following table shows interventions with sufficient scientific evidence for reducing mortality among under fives in developing countries. These interventions respond to an epidemiological pattern of child mortality in the countries of sub-Saharan Africa which is consistent with the Angolan pattern of causes of death.

**Graph N° 8: Interventions with scientific evidence in reducing mortality among children under 5 years old.**

Interventions/ Problems	Malaria	Diarrhoea	Pneumonia	Neonatal asphyxia	Prematurity	Tetanus	Measles	Neonatal sepsis	HIV/AIDS	Mainnutrition
Antimalarial drugs	■				■					
Insecticide treated mosquito nets	■				■					
Oral Rehydration Therapy		■								
Antibiotics for dysentery		■								
Antibiotics for pneumonia			■							
Breastfeeding		■	■					■		■
Vitamin A	■	■								■
Vaccine against measles							■			
Vaccine against tetanus						■				
Vaccine against hemophilic Influenza type b			■							
Complementary feeding	■	■	■				■			■
Micronutrients in pregnancy					■					■
Clean birth						■		■		
Nevirapine during birth for HIV+ women									■	

Source: Modified from THE LANCET. Vol 362. Child Survival Interventions with sufficient or limited evidence of effect on reducing mortality from the major causes of under -5 deaths. 2003

These interventions, except the vaccine against Hib, are not new, and are mostly being implemented in the country, in general with low coverage and deficient quality, which reduces their effectiveness. Furthermore, in general they are offered in an isolated way without considering the integration and convergence needed to obtain a synergy that will allow a speedy and sustained fall in mortality.

The “essential integrated package of mother and child health care and services” defined by the Ministry of Health for application nationally, will be the main strategy for the accelerated reduction in maternal and under-5 mortality.

Universal access to the package of interventions seeks to avoid deaths and to protect foetal and child growth; it will be offered through 3 strategies: (1) fixed network of public, NGO and church health services; (2) advance and mobile health teams to care for vulnerable groups without access to health services, and (3) community and household based activities. Implementation of the package will make it possible to stimulate reconstruction and development of the municipal health services.

Based on the analysis of the proportional structure of mortality by cause, undertaken by G.Jones *Et Al*<sup>6</sup> for the region of sub-Saharan Africa in 2003, and the information on causes of death for under fives obtained from the Luanda cemeteries for 2001-2003, the following table was drawn up which presents an estimate of the possible number of avoidable deaths, considering the structure of causes and the effectiveness of interventions in two scenarios; one with high coverage – necessary to meet the target of 50% reduction in under-5 mortality – and the other of medium coverage of short term viability.

**Table N°6: ANGOLA: Estimate of annual number of avoidable deaths among under fives. 2004 -2008**

Disease or condition	Deaths/year without additional interventions		Effectiveness of interventions in the essential package	High expectation		Medium expectation	
	N°	%		Coverage expected	Deaths avoided/year	Coverage expected	Deaths avoided/year
<b>Malaria</b>	41,630	23%	85%	85%	30,078	60%	21,231
<b>Diarrhoea</b>	32,580	18%	88%	85%	24,370	60%	17,202
<b>Pneumonia</b>	27,150	15%	65%	85%	15,000	70%	12,353
<b>Measles</b>	3,620	2%	85%	85%	2,615	80%	2,462
<b>HIV/AIDS</b>	3,620	2%	48%	30%	521	15%	261
<b>Neonatal problems</b>	56,110	31%	48%	66%	17,951	39%	10,693
Asphyxiation of new born	16,290	9%	39%	65%	4,130	40%	2,541
Sepsis	14,480	8%	90%	65%	8,471	30%	3,910
Premature birth	12,670	7%	38%	60%	2,889	40%	1,926
Neonatal tetanus	3,620	2%	80%	85%	2,462	80%	2,317
Other neonatal problems	9,050	5%	0%	0%	0	0%	0
<b>Other causes of death</b>	16,290	9%	0%	0%	0	0%	0
<b>TOTAL</b>	<b>181,000</b>	<b>100%</b>	<b>78%</b>		<b>90,535</b>		<b>74,896</b>
<b>Percentage of avoidable deaths</b>					<b>50%</b>		<b>41%</b>

# 5

## Objective 2:

### Reduce by 30% child malnutrition

**Malnutrition** affects half the Angolan population under five years of age, and is an associated cause of death in two out of every three deaths in this age group. Malnutrition leads to a reduction in defences, increasing the risk of death from infectious diseases by 50%. Well nourished children have additional learning capacity, and they will be more productive in adulthood.

#### Analysis of the situation:

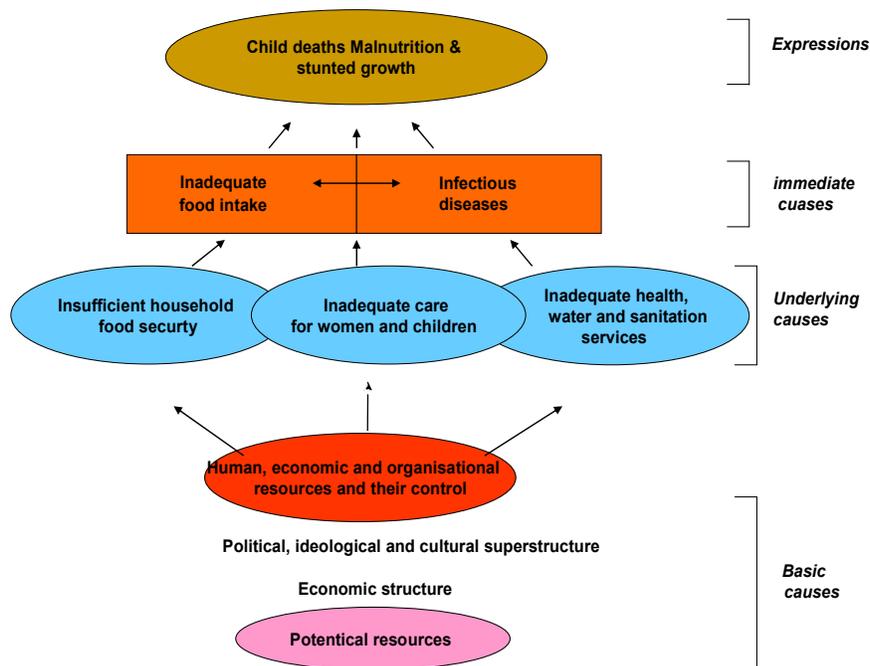
As a result of the war, about 3 million people from the rural areas were displaced into the urban centres, which unleashed a nutritional humanitarian emergency on a national scale, which needed foreign food aid to contain it. With the end of the armed conflict and the gradual return of displaced people and refugees to their places of origin, the emergency is being gradually overcome.

Child malnutrition results from a complex interaction of factors that act at the immediate, underlying and basic levels. The immediate level is determined by the interaction of inadequate intake of foodstuffs and the repeated infections from which the children suffer. The negative synergy between infections and malnutrition is well documented, and this happens throughout the population, not only in severely malnourished children. The joint impact of infections and malnutrition on child mortality is at least 50% greater than the effect of infections alone.

Three groups of causes act at the underlying level to determine malnutrition: (1) poor household food security; (2) insufficient access to primary health care in the health units and limited access to clean drinking water, and means for safe excreta disposal; (3) insufficient or inadequate care for children and women in the households.

At a more distant level, and operating on society as a whole, the basic causes of the high levels of mortality and malnutrition prevalent in the country are to be found. These determinants include the economic, political and cultural superstructure of Angolan society.

**Graph N°9: Conceptual framework of the factors determining the death, malnutrition and stunted growth of children.**



Source: UNICEF, Logical framework of the determinants of malnutrition

Chronic malnutrition or stunting, designated by the height to age indicator, affects 45% of the Angolan population under five years of age, resulting from shortages of food and frequent infectious diseases.

Acute malnutrition (on the weight to height indicator), also known as marasmus, shows a recent loss of weight resulting from lack of food and serious illness. It affects 6 % of the population under five years of age.

The weight to age indicator, also referred to as weight insufficiency or global malnutrition, and a combination of the two previous indicators, was estimated at 29% for Angolan under fives, which reflects the general nutritional situation of children, without considering whether the child is short or thin.

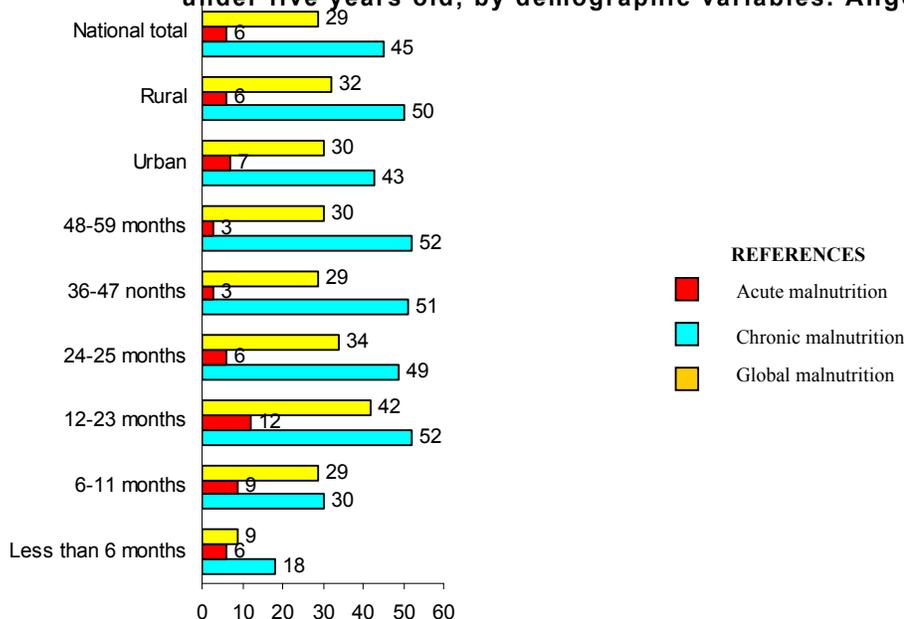
In Angola, the great majority of children who survive are denied a good start in life, due to the poor nutrition and health of their mothers during pregnancy, sometimes caused by successive pregnancies at short intervals. The health and nutrition of the pregnant woman will have effects on the child that will last throughout life.

A world analysis of failure of children to grow by weight shows that this is mostly concentrated in the period between 4 and 12 months of age, while the main failings to grow in terms of height are continual from birth until two years of age.

Like the mortality rates, the greatest prevalence of malnutrition is found among children from households in the worst socio-economic situation, and whose mothers have the lowest educational level.

No differences by sex are observed, and the differences by area of residence are small, with greater prevalence in the rural areas.

**Graph N°10: Prevalence of moderate and severe malnutrition in children under five years old, by demographic variables. Angola 2001.**



Source: National statistics Institute-UNICEF. Multiple Indicators Survey MICS. 2000.

Note: The percentage of moderate and severe malnutrition indicates the proportion of children under five who are between 2 and 3 standard deviations below the median for the age of the population in question. NCHS/OMS.

Children less than 6 months old show a lesser prevalence of malnutrition because during the first 6 months of life their mothers' milk guarantees the children's nutritional requirements. The highest prevalence is found among children aged between 12 and 23 months, a critical stage for feeding complementary to breast milk, and this feeding is inadequate for a great part of the people in this age group.

The distribution of malnutrition by region shows that all the regions have more or less the same level of acute malnutrition, except the western region which has twice as much, a factor which might partly explain the high rates of mortality observed in this region. The prevalence of chronic malnutrition is greatest in the south-central and southern regions, and lowest in the capital region. The highest absolute number of malnourished children is to be found in the capital and western regions, equal to their greater numbers of deaths of under fives.

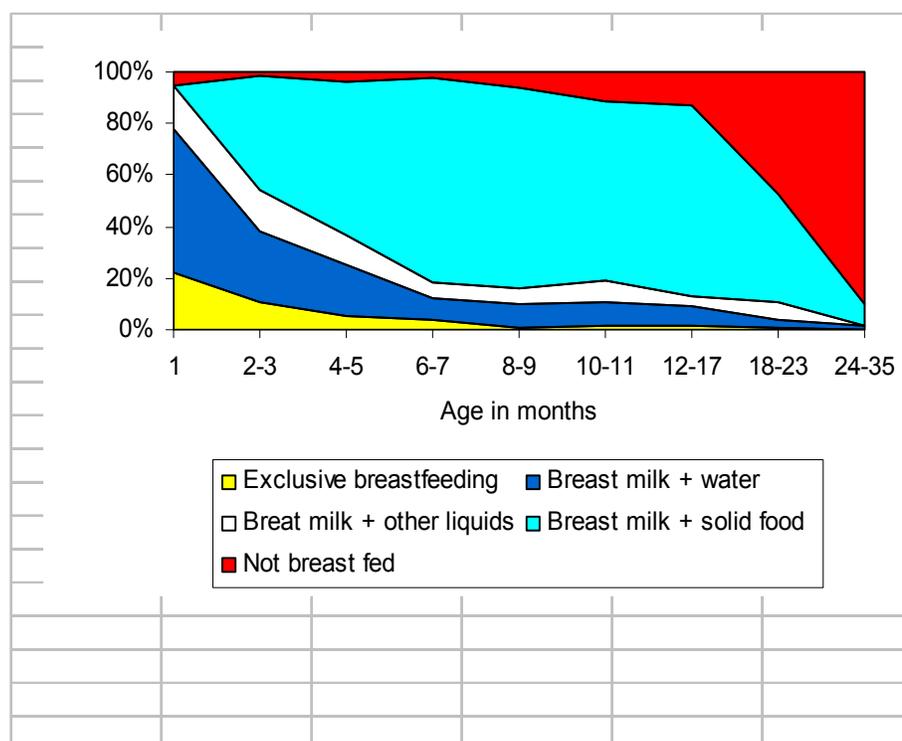
**Table N°2: Prevalence of malnutrition in children under 5 years old by area of residence and estimated number of malnourished. Angola 2001.**

REGION	% Chronic Malnutrition A/I	% Acute malnutrition P/A	N° malnourished under 5 P/I	% malnourished
<b>Centr3-South:</b> Huambo, Bié and Kuando Kubango	55	5	161,000	16
<b>South:</b> Huila, Namibe, Cunene	53	6	172,000	17
<b>North:</b> Zaire, Uige and Malange.	45	5	116,000	11
<b>West:</b> Benguela and Kuanza Sul	41	10	235,000	23
<b>East:</b> Lunda Norte, Lunda Sul and Moxico.	39	6	72,000	7
<b>Capital:</b> Luanda, Bengo, Kuanza Norte and Cabinda.	35	7	256,000	25
<b>TOTAL</b>	<b>45</b>	<b>6</b>	<b>1,012,000</b>	<b>100</b>

Source: National Statistics Institute-UNICEF. Multiple Indicators Survey MICS. 2001.

The MICS survey shows that breastfeeding continues, and that 89% of Angolan children are still being breastfed at 24 months of age. However, only 14% are exclusively breastfed in the first 6 months. Children less than 6 months old who are not exclusively breastfed have twice the risk of dying from diarrhoea or pneumonia than those who are<sup>1</sup>.

**Graph N°11: Pattern of feeding of children under three years old. Angola 2001.**



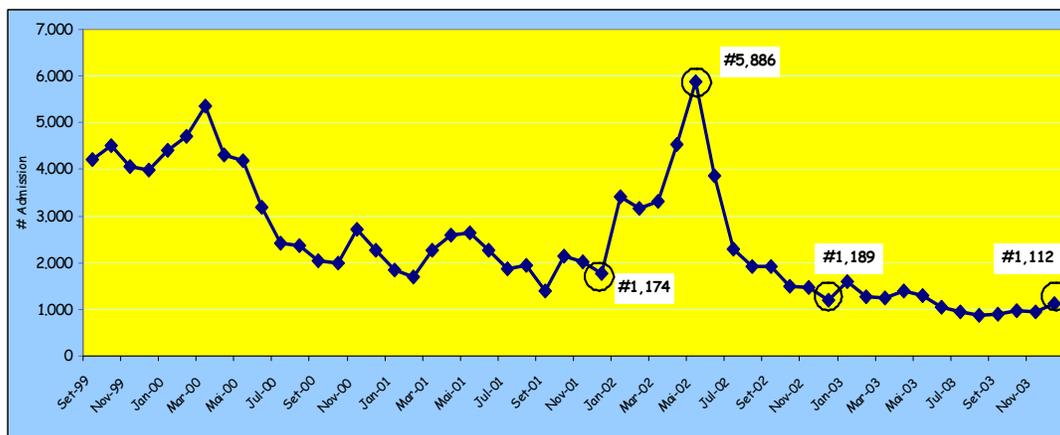
The introduction of water, other liquids or solids before 6 months of age is unnecessary because mother's milk fully covers the liquid and nutritional requirements of children under 6 months old.

It has been shown that the use of baby bottles can be a source of infection, especially in poor households. The MICs survey found that 26% of children drink from bottles; 18% in rural areas and 29% in urban areas.

Solid food given 4-6 times a day as a complement to breast milk is critical as from 6 months of age in order to maintain a good nutritional status. According to MICs only 77% of children aged from 6 to 9 months received solid food to complement their mothers' milk.

The following graph shows the evolution over the last 5 years at national level of admissions into the therapeutic nutritional centres of children in a state of serious acute malnutrition (weighing less than 70% of the median for their age, or edema).

**Graph N° 12: Number of admission of children with acute malnutrition in the therapeutic nutritional centres. Angola 1999 – 2003**



Source: UNICEF. Health and Nutrition section

The previous graph reflects the trend of the nutritional humanitarian emergency unleashed by the war, and its sharp reduction after the peace protocol was signed in April 2002. The peak in admissions to the therapeutic centres coincides with the end of the war. While the situation has improved nationally, the problem may remain in some provinces or municipalities.

There are no statistics on the coverage of monitoring child growth at the health units, but it is estimated at lower than 5%. The child health card includes the graph of monitoring weight for age of children under five, and is widely distributed during the vaccination of children under one year old.

## Micronutrient deficiencies

### Vitamin A deficiency

Vitamin A deficiency compromises the integrity of the epithelial barriers and of the immune system, and there is thus an added risk of death, particularly in children. In children with vitamin A deficiency there is an added risk of 20 to 24% of death from diarrhoea, pneumonia, measles or malaria<sup>5</sup>.

In Angola, the MINSA National Nutrition Programme undertook a study to determine the prevalence of vitamin A deficiency<sup>6</sup> and found that 64% of children aged 6 to 59 months were deficient in vitamin A (retinol sérico less than 20 µg/100 ml). In the milk of breastfeeding mothers a deficiency of 77% was found.

Since 1999, the Expanded Vaccination Programme has included the annual administration of a mega-dose of vitamin A for all children aged 6 to 59 months during the National Days of Vaccination against Polio. It was also given to children aged 9 to 59 months during the National Campaign of Vaccination against Measles in 2003. The coverage rates achieved were higher than 70%.

<sup>5</sup> Rice AL, West KP, Black RE. Vitamin A Deficiency. Unpublished document. Cited by Robert E Black The Lancet. Vol 361.

<sup>6</sup> Study on Vitamin A in Angola, Ministry of Health and UNICEF, 1998

Recently a vitamin A supplement was included for all children who consult the health services with 2 annual mega-doses of vitamin A; during the routine vaccination of children under one year old and during the general consultation of children aged 1 to 4 years. Also it is now normal to provide a supplement of a mega dose of vitamin A to breastfeeding women in the first eight weeks after the birth. The provision of vitamin A supplement during routine health activities is still lower than 15%.

### ***Iron deficiency anaemia***

Iron deficiency anaemia is an important health problem because of its negative impact on physical development, on increased maternal and foetal morbidity and mortality, and low weight at birth. Pregnant and lactating women and children under 5 years of age are at greater risk of developing iron deficiency anaemia. During pregnancy iron deficiency may be associated with folate deficiency. Anaemia is caused not only by inadequate food intake, but may also be worsened by malaria and intestinal parasites.

Iron supplements should be given to pregnant women in the second and third months of pregnancy, because even the best diet is not sufficient to meet requirements in this period of life.

In Angola, anaemia affects about 50% of children under 5 years of age, and 60% of pregnant women are anaemic. Currently the Health Ministry recommends giving pregnant women iron and folic acid supplements during the ante-natal consultations at the health units, but the coverage rates have not been determined. Children do not receive iron supplements.

### ***Iodine deficiency***

Iodine deficiency can lead to a larger number of stillbirths, neonatal mortality, congenital defects, cretinism and problems in mental and physical development. Apart from this, iodine deficiencies that are not visibly expressed reduce school performance and productivity.

Preventing iodine deficiency is one of the major interventions for human development, and is imperative to increasing the country's productivity and competitiveness.

Iodine deficiency is prevented by iodising salt. This strategy makes it possible to achieve a high coverage of the population, since salt is used by most households. In 1996 the Angolan government promulgated a decree making it compulsory that only iodised salt be distributed for human and animal consumption. But so far it has not been possible to apply the decree fully.

While Angola has potentially a self sufficient productive capacity, the use of iodised salt is still very low. The MICs 2001 survey showed that only 35% of households were consuming iodised salt, and 13% did not consume salt. The level of consumption of iodised salt in Angola is far below the average consumption in the countries of sub-Saharan Africa, estimated at 67% for the same period.<sup>7</sup>

## **Strategic approach:**

The capacity of the Angolan state to guarantee basic nutrition for all households forms part of the National Strategy for the Struggle against Poverty, and it will require long term investments in agriculture, employment and general development, seeking to attain food security as a universal right.

Over the short and medium term, supplementary feeding actions focused on vulnerable groups and attention to serious cases of acute malnutrition in the existing health services will also be very important.

However, the top priority will be given to protecting the foetal and infant growth of children in general, and to the immediate causes of growth failure, that is to the inadequate intake of food, including exclusive breastfeeding in the first six months of life, inappropriate practices of feeding small children, particularly during infections, and micronutrient deficiencies, particularly vitamin A in children under five and lactating women, and iron and other micronutrients in pregnant women and under fives.

---

<sup>7</sup> UNICEF State of the World's Children 2001.

Nutritional vigilance will be strengthened, using key indicators that will be monitored at all levels, to identify problems, activate emergency actions and assess whether the strategies adopted are producing the desired results.

These actions are included in the “*essential integrated package of mother and child health care and services*” advocated by MINSA. Universal access to the package of interventions seeks to avoid deaths and protect foetal growth and the growth of children under the age of five.

Also in the short and medium term the strengthening with micronutrients of foods of mass consumption will be prioritised because of the high cost/effectiveness of this intervention. It will contribute to reaching the nutrition targets and attaining the right to adequate nutrition.

In coordination with the Ministries of Fisheries and Industry, the legal norms for the iodisation of nationally produced salt and for imports will be updated, and control mechanisms to ensure compliance with iodisation norms will be improved.

## 6

**Objective 3:****Reduce maternal mortality by 30%**

*The maternal mortality rate in Angola is one of the highest in the world, estimated at 820 to 1,280 deaths per 100,000 live births<sup>8</sup>. In absolute numbers, this rate means about 11,000 maternal deaths and 33,000 children orphaned every year. This tragedy brings damaging consequences for society, particularly for the survival and care of children.*

**Analysis of the situation:**

Given the lack of vital statistics, the estimates of maternal mortality are based on the 1994 household survey in Luanda, using an indirect technique known as the sisters method, which estimated maternal mortality at 1,280 deaths per 100,000 live births, and data on hospital maternal mortality. The rate of hospital maternal mortality was estimated<sup>9</sup> at 600 maternal deaths per 100,000 live births. Which is 12 times higher than in other developing countries.

Maternal death is the final expression of a multiplicity of causal factors that operate at various levels. Poverty, the low status of women in the household and in society, and poor access to education explain the high rates of maternal mortality at the structural level. Age at the moment of giving birth is an important risk factor: the maternal death rate is 2-3 times higher among adolescents and women over 39 years old.

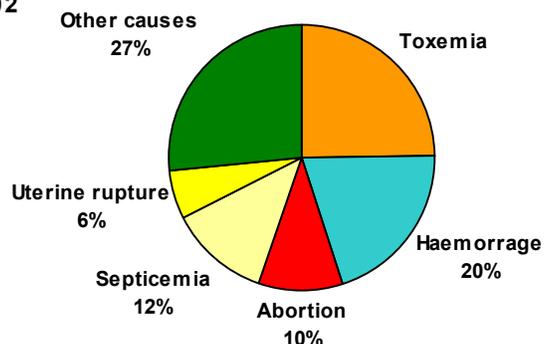
Women's health problems, particularly malnutrition and anaemia, low access to counselling/family planning services, ante-natal care and care at birth, and mainly the small number and poor capacity of the obstetric reference centres, added to the geographical, cultural and economic barriers to care, determine low maternal survival.

Lack of information at household level on the signs of the danger of maternal death, delays in seeking care, and lack of rapid access to means of transport, all make major contributions to the tragedy.

The direct causes of maternal deaths are complications in pregnancy, birth and after birth, which occur in about 15% of all pregnancies. Many of these complications require emergency obstetric care in centres with skilled staff, adequate surgical equipment, a safe blood supply, and sufficient drugs, which are generally not available in the health units. Malaria is the main cause of maternal death for non-obstetric causes.

The following graph shows the structure of the direct causes of maternal death in 893 deaths reported to MINSA in 2002 by the public sector health units.

**Graph N° 8: Angola: Structure of the direct causes of hospital maternal mortality, 2002**



<sup>8</sup> UNFPA. The State of the World's Population 2003. Selected indicators pag.70. Ratio of maternal mortality 820x100.000 n.v.

<sup>9</sup> Project CAOL Maternity Wards Lucrecia Paim and Augusto Cangula. 1996.

The coverage rate of ante-natal and birth care is low and shows the limitations of the health system in responding to the needs of the public. Ante-natal care has not always included iron and folic acid supplements, anti-malarial prophylaxis is practically non-existent, and the detection and handling of high blood pressure illnesses is scarce. Most births take place at home due to the low capacity installed in the health services, and dominance of traditional culture.

According to the MICs-2001 survey, at national scale, 61% of pregnant women received at most one ante-natal consultation (MINSa advocates 3 consultations) and only 38% of births were assisted by trained staff. Ante-natal care from a doctor only reached 12%, falling to 6% for a doctor present at birth. 49% of ante-natal care and 32% of care at birth were undertaken by technical health staff. In this case there is also the same falling off of care from the ante-natal consultation to birth

**Table N°3: Coverage of ante-natal care and care at birth, according to the staff who provided the care. Angola 2001.**

Socio-Economic situation	% Doctor		% Health technicians	
	Ante-natal	Birth	Ante-natal	Birth
Population with worst conditions (Q-1)	10	3	35	16
Population with best conditions (Q-5)	18	11	64	53
<b>Region</b>				
Centre-South: Huambo, Bié and Kuando Kubango	3	3	50	32
South: Huila, Namibe, Cunene	13	7	58	37
North: Zaire, Uige and Malange.	12	3	48	31
West: Benguela and Kuanza Sul	17	9	50	35
East: Lunda Norte, Lunda Sul and Moxico.	14	4	39	29
Capital: Luanda, Bengo, Kuanza Norte and Cabinda.	12	10	51	32
<b>Level of mother's education</b>				
None	7	3	36	19
Primary	12	6	54	35
Secondary to Higher	23	12	63	63
<b>Area of residence</b>				
Urban	14	7	52	38
Rural	7	1	41	19
<b>National Total</b>	<b>12%</b>	<b>6%</b>	<b>49%</b>	<b>32%</b>

Source: National Statistics Institute-UNICEF. Multiple Indicators Survey MICS. 2001.

The data on ante-natal care, obstetric complications, micronutrient supplements, and pathology reference are too insufficient, incomplete and late to monitor activities and problems.

The available data on births attended in the health services show that in 2002, 240,599 women gave birth in public sector health units. This means that only 29% of births took place in institutions, and that over two thirds of births took place at home, with the risks inherent to this.

Of the institutional births, more than half – 131,920 – took place in health centres with an average of 530 births per year per centre. The reference hospitals attended to 108,679 births with an average of 4,180 births per year.

The high fertility rate – average of 7 children per woman of child-bearing age – and the high proportion of adolescent pregnancies – before the age of 18 a third of Angolan women are already mothers – provide greater exposure to the risk of death and are at the root of high maternal mortality.

Family planning is a health intervention that makes it possible to reduce maternal and foetal deaths by avoiding unwanted and successive pregnancies without proper spacing. The family planning programme is not very well developed. Only 6% of married women and women in de

facto unions aged between 15 and 49 use contraception<sup>10</sup>: that is four times lower than the average for sub-Saharan Africa which is estimated at 23%.

The national capacity to attend to obstetric complications is sparse and is concentrated in the provincial capitals.

**Table N°4: Indicators of availability of centres for essential obstetric care. Angola 2002**

Province	Births expected 2002	Health Centres			Obstetric reference hospitals				
		N° of centres	Births attended	% coverage	N° hospitals	No. per 500.000 inhab	Births attended	% coverage	% Caesareans relative to expected births
Bengo	10,840	2	328	3	1	2.2	N.d.	n.d.	n.d.
Benguela	126,424	25	11,565	9	2	0.4	9,487	8	0.4
Bié	53,581	7	3,381	6	1	0.4	3,381	6	0.4
Cabinda	21,159	11	9,931	47	1	1.1	8,706	41	1.6
Cunene	16,648	8	1,772	11	1	1.4	1,518	9	0.1
Huambo	52,054	36	12,722	24	1	0.5	4,284	8	0.9
Huíla	76,048	21	8,974	12	1	0.3	6,437	8	0.7
K. Kubango	17,138	4	606	4	1	1.4	381	2	0.1
Kwanza Norte	16,261	12	1,457	9	1	1.5	1,013	6	0.5
Kwanza Sul	46,908	18	3,234	7	2	1.0	2,677	6	0.1
Luanda	214,829	34	54,430	25	4	0.4	54,430	25	3.0
Lunda Norte	27,358	5	3,302	12	2	1.7	2,612	10	0.2
Lunda Sul	12,677	3	2,126	17	1	1.9	1,804	14	0.4
Malange	21,881	18	1,189	5	1	1.1	1,189	5	0.6
Moxico	22,798	14	1,594	7	1	1.0	1,377	6	0.2
Namibe	9,133	6	2,061	23	1	2.6	1,527	17	1.6
Uíge	55,926	19	9,733	17	2	0.8	5,399	10	0.8
Zaire	10,852	6	3,515	32	2	4.4	2,457	23	0.9
<b>TOTAL</b>	<b>812,514</b>	<b>249</b>	<b>131,920</b>	<b>16 %</b>	<b>26</b>	<b>0.8</b>	<b>108,679</b>	<b>13 %</b>	<b>1.2</b>

Source: Ministry of Health -Angola. Studies, Planning and Statistics Office.

The indicator of the availability of at least one centre of basic obstetric care (health centres) for every 125,000 inhabitants for care at birth and diagnosis and treatment of obstetric complications is complied with in all provinces, but considering the size of the country and the dispersal of the rural population, geographical access can be a difficult barrier to overcome, a hypothesis that is strengthened by the very low percentage of births that take place in those centres, which do not reach 15% coverage in 11 of the 18 provinces. Other barriers that should be considered are economic and cultural.

Thus it is very unlikely to detect and treat in the health centres the obstetric complications which it is known take place in 15% of pregnant women. In many cases, the drugs and blood needed are not available in the health centres. Furthermore it is difficult to refer obstetric emergencies immediately since there is no established reference system because of the sparse public transport and the lack of vehicles at the health centres to transport cases.

The indicator for centres of comprehensive essential obstetric care (obstetric reference hospital) shows that the number of these centres is less than the minimum of 1 centre per 500,000 inhabitants in 6 of the country's 18 provinces. The coverage rate of births attended to in these centres is less than 15% of the births expected in 13 of the 18 provinces, which greatly limits their effectiveness.

<sup>10</sup>National Statistics Institute- UNICEF. MICS 2001. Main Demographic Characteristics. 2001

The indicator of caesareans, which should be between 5 and 15% of expected births, only reaches 1.2% and is not adequate in any of the 18 provinces. The geographical, economic and cultural barriers indicated for the basic centres of obstetric care are still greater for reaching the comprehensive centres. In Luanda where practically the entire population has geographical access to the obstetric care centres, the availability of the public centres is only sufficient to attend to 50% of the needs.

Furthermore, one notes in the public maternity wards and reference hospitals in general a dramatic shortage of doctors, who in many cases cannot keep up with the demand, particularly for obstetric emergencies. On the other hand, failure to follow protocols for care, shortage of resources, and late request for attention in obstetric emergencies all lead to a low quality of care, with extremely high levels of institutional mortality.

**Table N°5: Estimate of the number of obstetric complications in Angola. 2004**

<b><i>Estimated no. of pregnant women: 860,000 (5% of total population)</i></b>
<b>Complications requiring emergency care:</b>
<b>129,000 (15% of the pregnant women)</b>
Sepsis: 15,480 cases (12% of complications)
Pre-birth and post-birth haemorrhage: 25,800 cases (20% of complications)
Prolonged birth/ obstructed birth: 7,740 cases (6% of complications)
Eclampsia (toxaemia): 32,250 cases (25 % of complications)
Other complications: 47,730 cases (37% of complications)

### **Strategic approach:**

Interventions at primary level to reduce maternal deaths are not very effective, since they do not intervene directly in solving obstetric emergencies, but they do have a certain degree of effectiveness, because during ante-natal care the pre-existing anaemia is improved which improves survival chances in the event of haemorrhage. Furthermore, during a “clean birth” attendance, the possibility of post-partum infection (septicaemia) are reduced.

Controlling anaemia caused by iron and folic acid deficiency will be prioritised. Anaemia is caused not only by iron deficiency, but also by malaria and intestinal parasites such as anquilostomiasis and schistosomiasis. For this reason the interventions will be daily supplements of ferrous sulphate and folic acid for pregnant women as from the third month of pregnancy and during the first month of breastfeeding. Systematic prophylaxis against malaria for pregnant women will form part of the package of interventions, as well as the use of mebendazol to remove intestinal parasites. These measures will be applied during ante-natal control and will be beneficial for the woman and the future child.

Vaccination against neonatal tetanus of all pregnant women who have not yet had the complete vaccination scheme will be promoted during ante-natal control and on occasions of the mothers’ visits to the health service to vaccinate their children.

Improved attendance at birth and of the newborn child by the health services will include the systematic use of modern equipment to monitor labour and detect risks. Attempts will be made to avoid bloody procedures such as episiotomy, or dangerous manoeuvres such as internal turning to change manually the position of the child in the uterus, and the procedures for neonatal reanimation will be improved. Immediately after the birth, the woman will be given vitamin A.

“Community midwives” will be given a simple clean birth kit, and vitamin A to be administered after the birth. The function of community midwives will focus on educational aspects of health promotion, family planning, prevention of diseases such as HIV/AIDS and malaria, and fundamentally to identify the signs of danger of maternal death.

The main function of maternity care at primary level is the detection and rapid reference of obstetric emergencies to the essential obstetric care services. Thus the impact on the reduction of maternal mortality will largely depend on improving the quality of attending to obstetric complications in the reference centres. It is estimated that 3,300 maternal deaths can be avoided every year through the joint action of the primary network and better use of the current installed capacity for essential obstetric care.

In order to improve reference, the essential obstetric care hospitals will be regionalised, so that each health unit in the primary network, and each community health agent knows where to transfer obstetric emergencies, and the hospitals organize the supply of services in an appropriate way. Local initiatives will be promoted in communities and neighbourhoods to identify and organise means of transport for the rapid transfer of emergencies.

The main intervention to reduce institutional maternal deaths will be strengthening the installed capacity in the centres of essential obstetric care, in terms of better organisation of staff, systematic use of protocols for attending to obstetric emergencies, and endowment of basic equipment, essential drugs, and safe blood to deal with complicated cases.

## 7

## The Health Services Network

### Analysis of the Situation:

The Angolan network of public services is distributed throughout the national territory, especially in the provinces on the Atlantic coast. The network is insufficient to cover the current needs of the population, because almost no significant investments have been made in the physical infrastructure in the past 30 years, a period in which the population has doubled in size, and particularly because many of the existing structures were devastated by the war, especially in the east, and in the country's rural areas.

The primary network includes the health posts, health centres and municipal hospitals. The terms "health centres" and "municipal hospitals" in general do not correspond to their complexity. A municipal health centre may have more beds than a municipal hospital. There is a lack of compliance with the existing regulations on construction, equipment and organisation.

**Table N°6: ANGOLA: Public sector health units, by complexity and functional state. 2002**

Province	Hospitals			Health Centres			Health posts		
	Functional	Not functional	No. per 100,000 inhab.	Functional	Not functional	No. per 20,000 inhab.	Functional	Not functional	No. per 5,000 inhab.
Bengo	5	1	2.3	2	1	0.2	30	57	0.7
Benguela	10	0	0.4	25	0	0.2	65	2	0.1
Bié	4	0	0.4	7	0	0.1	35	0	0.2
Cabinda	4	0	0.9	11	0	0.5	79	26	0.9
Cunene	2	0	0.6	8	0	0.5	52	0	0.8
Huambo	7	1	0.7	36	0	0.7	44	86	0.2
Huíla	6	0	0.4	21	3	0.3	99	166	0.3
K. K.									
Kubango	8	3	2.3	4	0	0.2	15	3	0.2
Kwanza Norte	2	0	0.6	12	0	0.7	27	0	0.4
Kwanza Sul	5	4	0.5	18	4	0.4	108	60	0.6
Luanda	13	0	0.3	34	0	0.2	13	0	0.0
Lunda Norte	5	0	0.9	5	10	0.2	12	28	0.1
Lunda Sul	3	0	1.2	3	0	0.2	32	57	0.6
Malange	10	1	2.3	18	2	0.8	50	48	0.6
Moxico	5	1	1.1	14	0	0.6	145	116	1.6
Namibe	2	0	1.1	6	0	0.7	33	0	0.9
Uíge	5	1	0.4	19	8	0.3	55	141	0.2
Zaire	4	0	1.8	6	0	0.6	32	0	0.7
<b>TOTAL</b>	<b>100</b>	<b>12</b>	<b>0.6</b>	<b>249</b>	<b>28</b>	<b>0.3</b>	<b>926</b>	<b>790</b>	<b>0.3</b>

Source: Ministry of Health. Studies, Planning and Statistics Office. Statistical Yearbook, 2003.

At the end of 2002, 12 % of hospitals, 11% of health centres, and 85% of health posts were not operational, because of the destruction or serious deterioration of their physical infrastructure, and lack of staff and of basic equipment.

The functioning health centres are sparse, and are concentrated in urban areas. The rural areas have few health posts. They are isolated, and in general have no support or supervision. With

the end of the war, and the return of 2 -3 million people to their communities of origin, the health service deficit has become sharper.

The prolonged armed conflict that the country suffered did not allow the articulation and development of networks of health services that add to the capacity to solve problems. There is no articulation, reference relations or complementarity between the primary, secondary and tertiary levels of the public sector health units.

The hospitals are the only health services that receive funds from the General State Budget for operational costs. The health centres and posts only receive funds for wages and essential medicines.

The distribution of the doctors and nurses working in the public health sector can be seen in the following table:

**Table N°4: Angola: Medical and nursing staff in the public system. 2002**

Province	Doctors				Nurses	
	Nationals	Foreigners	Total	No. per 1,000 inhab	N°	No. per 1,000 inhab
Bengo	11	6	17	0.08	259	1.2
Benguela	29	12	41	0.02	2,012	0.8
Bié	6	0	6	0.01	936	0.9
Cabinda	26	0	26	0.06	739	1.7
Cunene	8	3	11	0.03	326	1.0
Huambo	11	8	19	0.02	908	0.9
Huíla	33	4	37	0.02	1,277	0.8
K. Kubango	2	4	6	0.02	314	0.9
Kwanza					489	1.5
Norte	0	5	5	0.02		
Kwanza Sul	7	12	19	0.02	497	0.5
Luanda	471	106	577	0.13	4,904	1.1
Lunda Norte	16	8	24	0.04	481	0.9
Lunda Sul	8	5	13	0.05	417	1.6
Malange	5	4	9	0.02	539	1.2
Moxico	2	4	6	0.01	528	1.2
Namibe	11	11	22	0.12	477	2.6
Uíge	4	5	9	0.01	582	0.5
Zaire	2	0	2	0.01	352	1.6
<b>TOTAL</b>	<b>652</b>	<b>197</b>	<b>849</b>	<b>0.05</b>	<b>16,037</b>	<b>1.0</b>

Source: Ministry of Health. Studies, Planning and Statistics Office. Statistical Yearbook 2003.

An analysis of the human resources in health shows an extreme shortage of doctors and an inequitable distribution of the human resources. The rate of 0.05 doctors per 1,000 inhabitants in the country's public sector is 20 times less than that recommended by the WHO and the rate for nurses is 3 times less.

Luanda contains 68% of the country's doctors, although only 25% of the Angolan population lives in this province. On the other hand, even in Luanda, the rate of doctors in the public sector per 1,000 inhabitants is 8 times less than the recommended figure of 1 doctor per 1,000 inhabitants.

Given the huge shortage of doctors and other university-trained health professional, the Angolan health system is largely staffed by technical nursing personnel who carry out health care functions, with the consequent limitations for solving health problems.

There are management difficulties at provincial and municipal level. One notes the lack of technical and administrative professionals in the intermediate levels of health management, and the lack of an administrative and financial system. This makes appropriate use of funds and accountability difficult. The system of staff organisation and assessment is incipient. Continual training is scarce, does not cover all the staff, and is only given for some public health programmes.

The network of community health promoters who were widely supported by MINSA in the past is currently de-activated, with the exception of the community midwives. There are broad networks of voluntary health activists in the communities and neighbourhoods who were organised for the national vaccination campaigns and take part regularly in promoting health activities

## 8

## Essential package of interventions

To ensure accelerated reduction of mortality among under fives and maternal mortality, it will be necessary to implement cost-effective and equitable intervention packages on a national scale, that respond to the epidemiological pattern of mortality, and the specificities of the Angolan health system, and which are economically sustainable over the long term.

The package of interventions is the key strategy for improving the quality of life of mothers and infants, and will help stimulate the reconstruction and development of local health systems.

The “essential package of mother and child health care and services” includes simple interventions that are relatively low cost and highly effective. It is based on the minimum package used by the Ministry of Health to attend to recently accessible populations during the emergency period. The “essential package of mother and child health care and services” will be provided to the target populations in an integrated form in order to have a synergetic effect – that is, the package will have a greater impact than the sum of the isolated effects of the interventions.

The package will be offered, seeking universal coverage, through three strategies: (1) the fixed network of services; (2) advance and mobile health teams to attend to vulnerable groups without access to health services; and (3) community and household based activities.

### **Package of interventions for the fixed network of health units:**

To meet the demand from the population accessible to the public sector health units, the standardised package of mother and child care and services will be offered. Through agreements, MINSA will ensure that the NGO and church health services adhere to the offer of the mother and child package.

The package for children includes: growth monitoring, vaccinations and micronutrient supplements, out-patient treatment of malaria, diarrhoea, IRAs and intestinal parasites, as well as appropriate personal counselling.

The package for maternal health includes ante-natal care; micronutrient supplements, anti-malaria prophylaxis, vaccinations and removal of parasites, care at birth and of the new-born child, and care after birth, including further micronutrient supplements.

Counselling on identification of signs of danger, prevention and treatment of diseases will be systematic. Identification and reference of obstetric emergencies to an appropriate centre will be a fundamental task of the primary network.

**Table Nº 3 Essential package of mother and child care and services at the level of the primary health services.**

Child Health	Maternal Health
<p><i>Preventive care</i></p> <ul style="list-style-type: none"> <li>Growth monitoring</li> <li>Vaccination</li> <li>Administration of vitamin A</li> <li>Administration of iron syrup</li> </ul> <p><i>Appropriate treatment of cases:</i></p> <ul style="list-style-type: none"> <li>Malaria</li> <li>Diarrhoea</li> <li>Acute Respiratory Infections</li> <li>Removal of parasites</li> </ul> <p><i>Counselling:</i></p> <ul style="list-style-type: none"> <li>Identification of signs of danger to seek attention.</li> <li>Compliance of treatment of diseases.</li> <li>Feeding during common illnesses.</li> <li>Compliance with monitoring of child growth</li> <li>Compliance with the vaccination scheme</li> <li>Breast feeding</li> <li>Appropriate complementary feeding</li> <li>Early stimulation</li> <li>Use of treated mosquito nets</li> </ul>	<p><i>Ante-natal care</i></p> <ul style="list-style-type: none"> <li>Administration of iron + folic acid</li> <li>Presumptive intermittent treatment against malaria</li> <li>Anti-parasite treatment</li> <li>Vaccination against Tetanus</li> </ul> <p><i>Care at birth and of the new-born child</i></p> <ul style="list-style-type: none"> <li>Antibiotics in case of premature rupture of membranes</li> <li>Clean birth</li> <li>Resuscitation of the new-born child</li> <li>Administration of Nevirapine to HIV+ mothers (Maternity wards)</li> <li>Administration of vitamin A after the birth.</li> </ul> <p><i>Counselling:</i></p> <ul style="list-style-type: none"> <li>Identification of signs of danger of complications</li> <li>Prevention and voluntary testing for HIV/AIDS</li> <li>Use of treated mosquito nets</li> <li>Rest and feeding during pregnancy</li> <li>Compliance with the treatments and vaccination</li> <li>Preparation for the birth</li> <li>Breast feeding</li> <li>Spacing between births</li> </ul>

### **Package of interventions for mobile and advance health teams**

To care for vulnerable groups of the peripheral urban areas or nearby rural areas, advance health teams will be organized with health technicians from the health units or municipal headquarters. These teams will undertake regular programmed sessions with wide-ranging social mobilization to guarantee participation by the target population.

Villages and rural communities without health services will receive regular visits from mobile health teams who travel every month or quarter from the municipal or provincial headquarters to offer the package of mother and child interventions to the target populations for several days. These visits will be programmed and coordinated in advance with the traditional authorities.

The regular preventive interventions such as vaccination and vitamin A supplements are the most effective for this type of strategy, and will thus be the backbone of the activities of the mobile and advance teams to which other activities will be added. To follow up the health activities of the mobile and advance teams, it will be necessary to coordinate this activity with the tasks of the community health agents who live in the communities visited.

**Table N° 4 Essential package of mother and child care and services to be applied by mobile and advance health teams.**

Child Health	Maternal Health
<p><i>Regular preventive care</i></p> <ul style="list-style-type: none"> <li>Vaccination</li> <li>Administration of vitamin A</li> <li>Removal of parasites</li> <li>Distribution of treated mosquito nets</li> <li>Re-treatment of mosquito nets</li> </ul> <p><i>Appropriate treatment of cases:</i></p> <ul style="list-style-type: none"> <li>Malaria</li> <li>Diarrhoea</li> <li>Acute Respiratory Infections</li> </ul> <p><i>Counselling:</i></p> <ul style="list-style-type: none"> <li>Identification of signs of danger to seek care.</li> <li>Compliance of treatment of diseases.</li> <li>Feeding during common illnesses.</li> <li>Compliance with the vaccination scheme</li> <li>Breastfeeding</li> <li>Use of treated mosquito nets</li> </ul>	<p><i>Ante-natal care</i></p> <ul style="list-style-type: none"> <li>Identification of pregnant women at risk</li> <li>Administration of iron + folic acid</li> <li>Presumptive treatment against malaria</li> <li>Removal of parasites</li> <li>Vaccination against Tetanus</li> </ul> <p><i>Counselling</i></p> <ul style="list-style-type: none"> <li>Identification of signs of danger of complications</li> <li>Prevention of HIV/AIDS</li> <li>Use of treated mosquito nets</li> <li>Rest and feeding during pregnancy</li> <li>Preparation for the birth</li> <li>Breastfeeding</li> <li>Spacing between births</li> </ul> <p><i>Identification of means of transport in order to refer obstetric emergencies</i></p>

### **Package of interventions for community-based activities**

Community based health activities, aimed at contributing to the accelerated reduction of under-5 and maternal mortality, will have three modes of implementation:

- (a) Health promotion and care activities for populations without access or with difficult access to health services, to be undertaken by **community health agents** who will mainly undertake child care activities and **community birth assistants** (upgraded traditional midwives) who will promote maternal health.
- (b) Malaria prevention activities, promotion of the use of insecticide-treated mosquito nets, and re-treatment of the nets in the communities, undertaken by those in charge of **insecticide treatment units** (UTIs).
- (c) Information, education and communication activities, to be undertaken nationally, in urban and rural areas, by **social activists or mobilisers** of grass roots social organisations, such as scouts, religious organisations, youth organisations etc., who will promote the demand for the services of health units, and the democratization of appropriate health knowledge and practices.

The package of mother and child care to be implemented by community and neighbourhood health volunteers can be seen in the following table:

**Table N°5 Essential package of mother and child care for community and neighbourhood voluntary health agents.**

<p><b>Community Health Agents</b></p> <p><i>Appropriate handling of cases:</i>  Malaria at all ages  Diarrhoea in children (oral rehydration)  Acute Respiratory Infections in children  Regular removal of parasites in children and pregnant women  Regular vitamin A supplement for children</p> <p><i>Transfer of severe cases to the health services</i>  Identification and timely organisation of means of transport</p> <p><i>Counselling and promotional activities:</i>  Identification of signs of danger to seek care.  Compliance with treatment.  Exclusive breastfeeding  Feeding during common illnesses.  Use of treated mosquito nets  Use of clean water, use of latrines and personal hygiene  Prevention of HIV/AIDS</p>	<p><b>Community birth assistants (Midwives)</b></p> <p><i>Ante-natal care</i>  Administration of iron + folic acid</p> <p><i>Care at birth and of the new-born child</i>  Clean birth (clean birth kit)  Administration of vitamin A immediately after birth</p> <p><i>Counselling:</i>  Identification of signs of danger of obstetric complications.  Use of treated mosquito nets  Prevention of HIV/AIDS  Breast feeding  Spacing between births</p> <p><i>Transfer of obstetric emergencies to reference hospitals</i>  Identification and timely organisation of means of transport.</p>
<p><b>Those in charge of Mosquito Net Treatment Units (UTIs).</b></p> <p><i>Distribution/sale of treated mosquito nets:</i>  Current nets treated  Long lasting pre-treated nets.</p> <p><i>Regular treatment with insecticide</i>  Current nets  Screens</p> <p><i>Counselling and promotional activities:</i>  Promotion of use of mosquito nets  Adequate use of treated mosquito nets  Identification of signs of danger of cases of malaria to seek care.  Promotion of malaria prophylaxis for pregnant women</p>	<p><b>Activists from grass roots social organisations</b></p> <p><i>Promotion of demand for health services:</i>  Routine vaccination for children and pregnant women  Care for common diseases  Ante-natal control  Care at birth</p> <p><i>Democratisation of appropriate health knowledge and practices in households</i>  Exclusive breastfeeding  Feeding of small children  Identification of signs of danger in children and pregnant women  Prevention of HIV/AIDS  Use of treated mosquito nets by children and pregnant women  Use of clean water, use of latrines and personal hygiene</p>

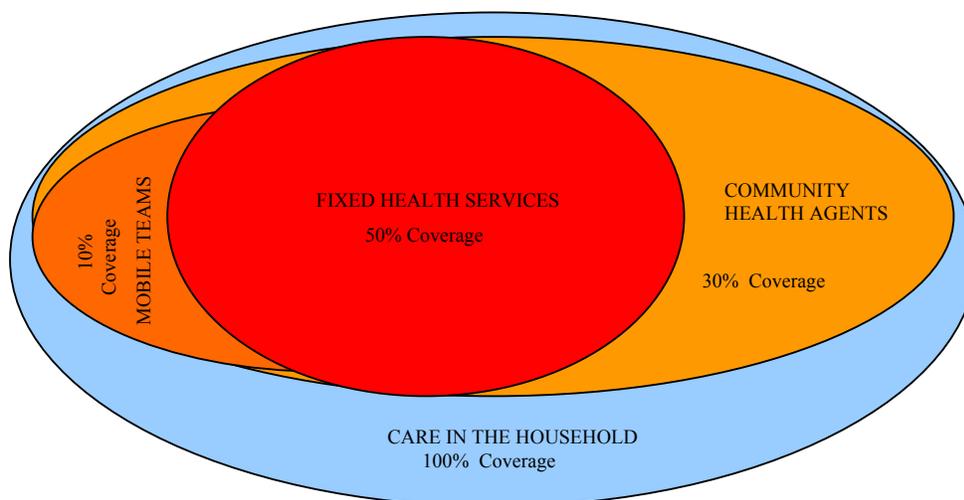
## 9

## Strategies to expand coverage

Since only about 30-40% of the Angolan population currently has access to health services, implementation at national level of the “*essential integrated package of mother and child health care and services*” must necessarily undertake strategies to expand coverage, which makes it possible to attain coverage rates higher than 80%, seeking universal coverage.

The following graph shows the general strategy for expanding coverage to reach 80% coverage: 50% coverage through the fixed network, and the remaining 30% through the combination of advanced teams and community agents. This also seeks universal coverage in information, education and communication to households to strengthen them in caring for and protecting children and pregnant women.

**Graph N° 9:** Strategies for expanding coverage to implement the integrated package of mother and child health care and services



### Strategies for expanding coverage include:

- Better use of the installed capacity of the health services, especially the primary network, ensuring the integrated supply of high quality mother and child care and services, and not merely isolated interventions;
- Activities to promote demand for health services, aimed at population groups currently without care, but with geographical access, through communication and mobilization by voluntary community or neighbourhood activists, and the mass media.
- Recruitment, training and support for community health agents to implement the simplified package of health promotion care and services in neighbourhoods and communities without health coverage.
- Provision of health care through advance and mobile health teams that regularly visit neighbourhoods and villages without health services, in order to administer preventive interventions and care, and to support the community agents;

- Improvement of household knowledge and practices of care for children and mothers through activities of inter—personal information, education and communication, complemented with radio education programmes in Portuguese and in national languages.
- Assessment of the needs of non-functioning health units, followed by rehabilitating and equipping them to make them operational.

### ***Better use of the fixed health services***

Because the interventions in the package are simple to apply, relatively low cost and highly effective, they will be offered in all health services (public and those run by NGOs and churches) except for the use of anti-retroviral drugs to prevent mother-to-child transmission of HIV, which will be undertaken only at selected centres with institutional birth attendance capacity, counselling on HIV prevention and voluntary testing, and access to HIV laboratory diagnosis.

For effective implementation of the package in order to add **effective use** of the services, it will be necessary to prepare supply through: adjustment in the organisation of care in each health unit so as to motivate all staff, guarantee attention within the established timetable, make use of all opportunities to offer the complete package, strengthen the counselling of users to complete the vaccination doses or treatments that require more than one consultation, and improve the timely supply of vaccines, essential drugs and expendable materials.

### ***Expansion of coverage through advance teams***

This is a strategy to expand coverage, and complement care in the health units. It allows care for the peripheral urban or rural population who live in a 5-10 km radius from health services, but who because of cultural barriers, or the cost of travel, do not use the health service or use it infrequently.

For successful implementation, the identification of pockets with low coverage or populations with poor access should be guaranteed, local leaders and the public should be informed in due time by social mobilisation activists of the time and place of attendance in a widely known place such as a market, church or school. The advance teams should carry out their visits in a systematic (monthly or quarterly) way, and on the same days of the week so as to win the trust and participation of the population.

### ***Expansion of coverage through mobile teams***

This strategy is used to reach rural communities who have difficult access or no access to health units (distance greater than 10 km). It will be used with skilled staff, mobile cold chain equipment (mini-ark and/or 7 day isothermic box) and vehicle. In general, the staff in the mobile team need to stay overnight in the communities attended.

Local leaders and activists should be informed and motivated in advance about the place and time people should gather for attendance. An annual timetable of visits should be followed, that will be complied with rigorously on a monthly or quarterly basis.

### ***Expansion of coverage through community health agents***

Health service activities will be broadened by a network of community health agents who will undertake promotion and education, and activities to deliver the *essential integrated package of mother and child health care and services*.

To relaunch, at national level, the community health agents, as the basis for the strategy of expanding coverage, a wide-ranging process of reflection and analysis will be necessary that considers the following concepts to guide the definition of a policy, use and regulation of community health agents:

- The urgent need to offer essential health interventions in communities without health services;
- The selection of candidate community health agents by the traditional authorities and communities based on minimum criteria established by MINSA;
- The voluntary character of the participation of the community agents, and the absence of any promise of payment, or promise that community agents will be integrated as health staff by MINSA;

- The liaison between the community agent and a health unit for information, reference of serious cases, and supplies of medicines;
- The pledge of MINSA to offer training, the supply of a package of medicines and IEC materials, through presentation of information on the activities undertaken.



# **Strategy for improving the quality of care**

The main strategies for improving the technical quality of care, the satisfaction of the users, the motivation of staff, and increased effectiveness of health interventions are the training of human resources and following their performance. The actions envisaged include:

- On-the-job training of staff currently working in the public, NGO and church networks;
- Formative supervision of trained staff;
- Regular assessments and continual monitoring of the quality of care and user satisfaction;
- Revision of the curriculum and incorporation of up-to-date norms and methodologies in the mid-level and higher technical nursing schools and in the medical faculty.

The first three actions will bear fruit in the short term, and the fourth in the medium and long term.

## **Training**

For the training of health staff, 4 blocks of content have been identified:

- Integrated care for childhood illnesses (AIDI);
- Integrated reproductive health care (CISAR);
- Major endemic diseases (malaria, HIV/AIDS, STI, tuberculosis);
- Management for provincial and municipal levels.

Specific training in integrated epidemiological vigilance, routine vaccination, triage and treatment of acute malnutrition, and logistics and cold chain, will also be supported.

Implementing the training of health staff in AIDI and CISAR (including the malaria and HIV/AIDS components) has four stages:

- 1<sup>a</sup> Drafting/updating the integrated norms, educational material and information support;
- 2<sup>a</sup> Training “*nuclei of provincial trainers*” in the 18 provinces so as to create decentralized teaching capacity;
- 3<sup>a</sup> Training municipal facilitators;
- 4<sup>a</sup> Training institutional and community operational staff.

## **Formative supervision**

“*Formative supervision*” will be undertaken with the purpose of promoting quality results focusing on the joint identification and solution of problems, through regular planned visits.

The central level will supervise the provincial level and a sample of municipalities and health units. The provincial level will supervise the municipal level and a sample of health units and the municipal level will supervise all the health units.

A larger number of visits will be made to the levels or health units showing poor performance. The health programmes will coordinate supervision to make best use of means of transport, save resources, and avoid overloading those being supervised.

Multidisciplinary supervision will be undertaken from central level to the province, and from the province to the municipality, and integrated supervision from the municipalities to the health units.

During the supervisions, verification lists will be used to systematize observations. The supervisions should also be used to distribute materials and update information or reports.

## Monitoring and Evaluation Indicators of progress

The following details the main indicators that will make it possible to monitor and evaluate progress in implementing the plan. All the indicators will be processed for each municipality at central and provincial level. At municipal level 3 - 4 key indicators will be selected.

### Child health outputs expected

INDICATORS		Index Year	2004	2005	2006 2008
1	Percentage of malaria cases in under fives receiving standardised treatment.	2	20	50	80
2	Percentage of diarrhoea cases in under fives receiving ORT and continued feeding.	7	20	70	80
3	Percentage of pneumonia cases in under fives receiving standardised treatment.	3	30	50	80
4	Percentage of children under one vaccinated (DTP-3, Polio-3, measles, BCG and yellow fever).	46	60	70	80
5	Percentage of pregnant women vaccinated with TT- two or more doses	48	60	70	80
6	Percentage of municipalities with DTP-3 coverage of 80% or more	6	20	50	80

### Nutrition expected outputs

INDICATORS		Index year	2004	2005	2006 2008
1	Percentage of under fives whose growth is systematically monitored	n.d.	20	70	80
2	Percentage of children from 6 months to 4 years old who have received 2 doses / year of Vitamin A	n.d.	50	70	80
3	Percentage of under fives receiving anti-parasite treatment twice a year.	n.d.	40	70	80
4	Percentage of children under six months old who are exclusively breast fed	14	20	30	60
5	Percentage of children aged 6-24 months with appropriate complementary feeding	20	30	40	60
6	Percentage of health units undertaking triage for acute malnutrition	174	380	630	1.266
7	Percentage of pregnant women who have received 100 or more ferrous sulphate/folic acid pills	n.d.	60	70	80
8	Percentage of pregnant women with anti-parasite treatment	n.d.	60	70	80
9	Percentage of children identified with weight for height less than 70 % of the median for their age, or edema, who have received supplementary feeding	n.d.	90%	90%	90%
10	Percentage of pregnant women with brachial perimeter less than 23 cm who have received supplementary feeding	n.d.	90%	90%	90%
11	Percentage of mothers who have received Vitamin A after giving birth	n.d.	60	70	80
12	Percentage of households consuming iodised salt	35	50	80	90

## Reproductive health – expected outputs

INDICATORS		Index year	2004	2005	2006 2008
1	Number of provinces with 1 centre of comprehensive essential obstetric care for each 500,000 inhabitants.	18/18	18/18	18/18	18/18
2	Number of provinces with a reference system established for obstetric emergencies.	0	10	18	18
3	Percentage of pregnant women with 2 or more ante-natal consultations	61	65	70	80
4	Percentage of pregnant women with anti-malaria prophylaxis	2	60	70	80
5	Percentage of births in health units	40	50	70	80
6	Percentage of births attended by trained staff	38	50	70	80
7	Percentage of mothers with 2 or more post-natal consultations	1	10	30	50
8	Percentage of use of modern contraceptives among women of child bearing age	6	12	15	25
9	Number of health services that provide HIV and syphilis counselling and voluntary testing.		25	50	100
10	Number of health services that undertake prevention of mother-to-child transmission of HIV.	2	5	20	100

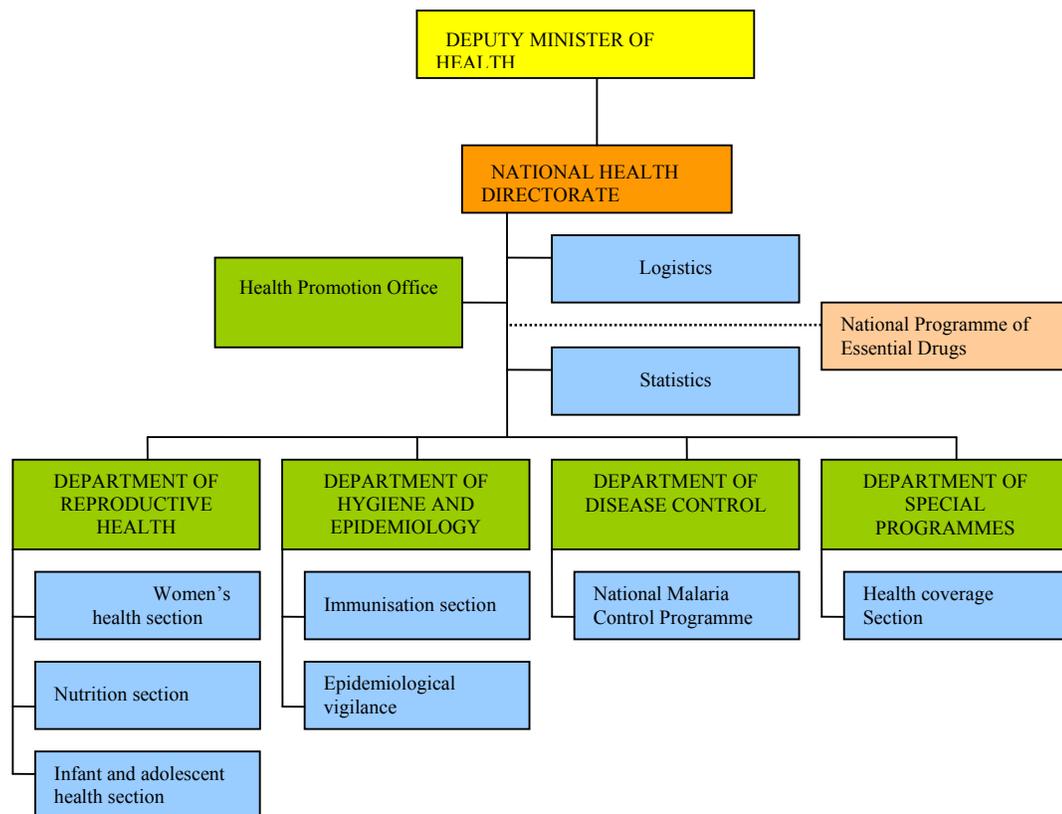
The Ministry of Health will be the body that implements the “Plan for Accelerated Reduction of Maternal and Child Mortality 2004-2008”. The Deputy Minister of Health will coordinate activities through the central executive body of the National Public Health Directorate.

The National Public Health Directorate will undertake its duties through the executive structure of the Hygiene and Epidemiology Department, the Reproductive Health Department, the Department for Control of Endemic Diseases, and the Department of Special Programmes.

These Departments will coordinate the sections and programmes involved in implementing the plan, namely: the Women’s Health Section, the Infant and Adolescent Health Section, the Nutrition Section, the Immunisation Section, the Health Coverage Section, the National Malaria Control Programme, and the Health Promotion Office.

The National Essential Drugs Programme, which depends on the National Directorate of Medicines and Equipment, will work in close coordination with the national programmes.

**Graph N° 9: Organic chart of the National Public Health Directorate**



For the integrated implementation of activities, two functional technical teams will be organised with thematic responsibilities: (a) **child health** formed by officials of AIDI, PAV, Nutrition, Health Promotion, Malaria and HIV/AIDS); (b) **reproductive health** formed by officials from Women’s Health, Nutrition, Health Promotion, Malaria and HIV/AIDS. Technical staff from WHO, UNICEF and UNFPA form part of the functional teams.

For accompanying and supporting the provinces, multi-disciplinary teams will be organised with territorial responsibility by regions: Capital Region: Luanda, Bengo, Kuanza Norte and Cabinda; Northern Region: Zaire, Uige and Malange; Centre-South Region: Huambo, Bié and Kuando Kubango, Southern Region: Huila, Namibe, Cunene; Eastern Region: Lunda Norte, Lunda Sul and Moxico, and Western Region: Benguela and Kuanza Sul.



# Partnerships and Coordination Mechanisms

## Need for joint and coordinated action

*To increase national capacity. The Ministry of Health will promote wide-ranging partnerships, and will strengthen the relationship with traditional partners, in the framework of the sustainable strengthening of health activities. To optimise resources, avoid duplication of efforts, and guide cooperation, coordination mechanisms will be defined, including the roles of each of the partners, considering their mandates and potential, seeking complementary and synergetic support for the benefit of the neediest population groups.*

### Strategic Approach:

The national government is responsible for the appropriate implementation of the Plan for Accelerated Reduction of Maternal and Child Mortality 2004 -2008, through its organizational structures at central, provincial, municipal and commune level.

Implementation of the Plan will help strengthen the normative and regulatory capacity of the Ministry of Health, stimulating the activities of the sector, promoting coordination and articulation between programmes and levels. At the same time, the process will demand greater coordination and complementarity with partner organisations at national, provincial and municipal level.

Coordination with partners and accompanying activities at national level will be undertaken through the Inter-Agency Coordination Committee (CCI). This will be set up on the basis of the CCI of the Expanded Vaccination Programme. It will be coordinated by the Deputy Minister of Health, who will be assisted by the National Director of Public Health. Other participants will be the heads of departments and programmes involved, the representatives of the WHO, UNICEF, UNFPA, USAID, EU, one representative of national NGOs, another of international NGOs and another of the Churches. The Committee will have regular monthly meetings, and extraordinary meetings when necessary.

With the aim of facilitating coordination and accompanying at provincial and municipal level the activities of NGOs and of the health services of churches and private bodies, local Coordinating Committees will be set up in the normative framework laid down by MINSa.

### Role of the partners:

#### Cooperation bodies

The World Health Organisation (WHO), which is the technical health body, will provide the technical assistance necessary for the planning, implementation and monitoring of the plan. In particular, cooperation will be required to define the intervention packages and for the development and evaluation of the health service systems.

The United Nations Children's Fund (UNICEF), which has the mission of ensuring the survival, development and protection of children, will also contribute technically and financially in the definition, implementation, monitoring and evaluation of the plan, particularly as regards activities of advocacy, communication and social mobilization, and in community and household based child-oriented activities.

The United Nations Fund for Population Activities (UNFPA) will contribute to the reproductive health activities, particularly in supporting communication activities for changes in the behaviour of young people, family planning counselling and services, and improved capacity of the centres of essential obstetric care.

USAID, the EU and other partner agencies will participate technically and financially in defining the plan, and accompanying its implementation.

The NGOS that work in health will undertake their activities in geographical areas agreed with the Ministry of Health, in the framework of the national norms and priorities, and under operational coordination with the provincial and municipal levels of health.

***Civil society organisations:***

The participation of churches will be encouraged in promoting, publicising and implementing the plan directly or through their organisation of youth, believers and health services. At national level, MINSA will coordinate actions with the Episcopal Conference and the Congress of Christian Churches.

Traditional leaders will be widely informed of the benefits of the care package, as will the grass roots organisations that exist in the communities, neighbourhoods or villages. Their support will be sought to promote demand for services and informative and educational health activities.

The organisation of health committees around each health unit will be promoted, as will the participation of representatives of local organisations and traditional leaders to monitor the activities and promote greater demand for services.

---