Malawi

Consolidated Emergency Report 2018

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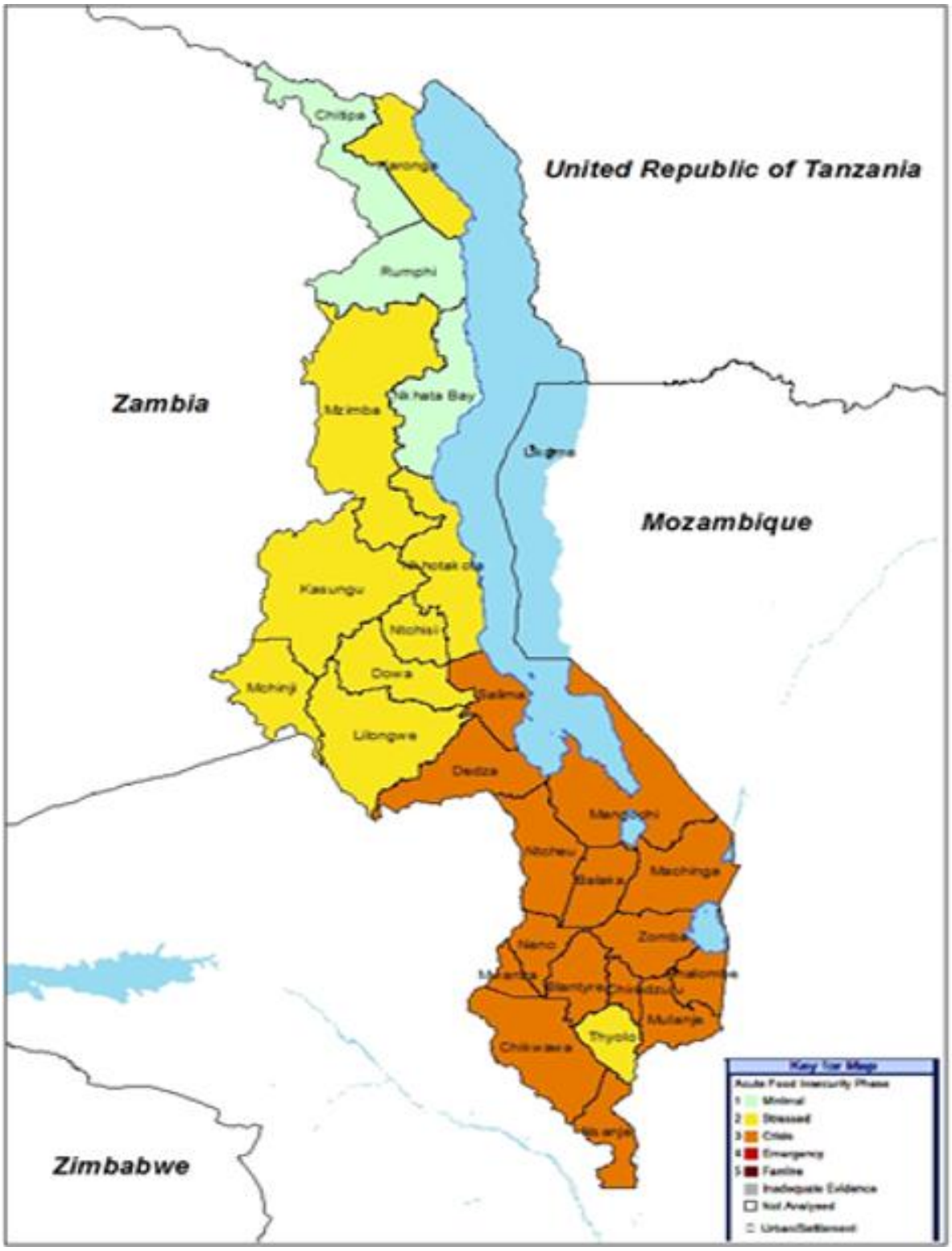


Abbreviations and Acronyms

CBCM	Community-based Complaints Mechanisms
CDC	Centre for Development Communications
CFR	Case Fatality Rate
CMAM	Community management of Acute malnutrition
CTC	Cholera Treatment Centres
DNHA	Department of Nutrition, HIV and AIDS
DSMC	District Social Mobilization Committees
EMT	Malawi Emergency Management Team
GBV	Gender-based violence
IPC	Integrated Food Security Phase Classification
LMIS	Logistics Management Information Systems
MIYCF	Maternal Infant and Young Child Feeding
MRC	Malawi Red Cross
MVAC	Malawi Vulnerability Assessment Committee
OCV	Oral Cholera Vaccine
OSC	One Stop Centres
PACHI	Parent and Child Health Initiative
SAM	Severe Acute Malnutrition
SEA	Sexual Exploitation and Abuse
SMART	Standardized Monitoring and Assessment of Relief and Transitions
WASH	Water Sanitation and Hygiene
WHO	World Health Organisation

Executive Summary

Malawi remained a shock-prone country in 2018. Following successive dry spells and floods in previous years, 2018 was marked by further droughts and heavy rainfall causing floods across the country. Food insecurity also remained a serious challenge in 2018. During the first quarter of 2018, a total population of 1,043,000 people were food insecure and required food assistance. The situation eased for a few months following the 2018 harvest in March and April. However, due to shocks experienced during the 2017/18 rainfall season, including dry spells, flooding, and an Army Worm infestation, the amount of food harvested was not adequate to meet the national food requirements. As a result, a total of 3,306,405 people was classified as acutely food insecure and provided with food assistance from October onwards.

Also, an outbreak of cholera affecting 939 people (475 M, and 464 F) in 13 districts. Approximately 10 percent of cases involved children under the age of five. A total of 32 deaths were registered. Additionally, flooding affected several districts, with Karonga most seriously affected. Approximately 816 households (587 male-headed and 231 females-headed), comprising 4,069 people, were affected in Karonga alone. The affected population included 157 under-five children, 133 elderly people, 66 physically challenged persons.

Throughout the resulting emergency response, UNICEF played a key role in strengthening intra- and inter-cluster coordination at national- and district-levels as the cluster co-lead agency for the Nutrition, Education, WASH and Child Protection clusters. For instance, UNICEF supported the mainstreaming of protection and GBV in other clusters (including Nutrition, Education, WASH, and Food Security), supported a disaster risk management training for the Education Cluster team, and developed an Emergency in Education Strategy.

UNICEF support contributed to the saving the lives of 40,729 (93.7%) children aged 6 to 59 months with severe acute malnutrition (SAM) who were admitted to CMAM program. Program performance indicators were all within the internationally agreed minimum SPHERE standards[1] .

To respond to the cholera outbreak, UNICEF used an integrated approach encompassing Health, C4D and WASH interventions. For instance, UNICEF supported the establishment of 22 Cholera Treatment Centres (CTCs) and covered their operating costs. To prevent the risk of gender-based violence, separate, well-lit service areas for females and males were provided in the CTCs. All CTCs had separate admission rooms for females and males. Prepositioning of supplies during the preparedness phase enabled timely dispatching to affected areas and contributed to the effectiveness of the response.

UNICEF supported a total of 351,599 men, women, girls and boys to access safe water in cholera and flood-affected districts and provided supplies for treatment of diarrhoea, pneumonia, LLIN, and vaccines for disease prevention in affected and flood prone districts in Malawi. Periodic monitoring visits were conducted, and technical advice and cold chain oversight was given.

[1] Cure rate above 75 per cent target, death rates below 10 per cent threshold and defaulter rates less than 15 per cent

Additionally, UNICEF supported the delivery of key cholera prevention messages, which contributed to preventing and containing the outbreak. A total of 3 million men, women, girls and boys in the affected as well as at-risk areas received key sanitation and hygiene promotion messages.

UNICEF also supported the Government to implement the Food Insecurity Response Plan, focusing on coordination, supporting mechanisms for prevention and response to all forms of violence, GBV and sexual exploitation and abuse (PSEA) through strengthening of community-based complaints mechanisms (CBCM), strengthening referral and survivor assistance frameworks and mainstreaming protection and GBV in other clusters. Furthermore, 16, 989 individuals including approximately 9, 000 children living in food insecure areas benefited from emergency cash top-ups.

1.0 Humanitarian Context

Malawi remained a shock-prone country in 2018. Successive and compounding climatic shocks over recent years, with limited recovery time, have driven cyclical humanitarian food needs. Agricultural production in 2018 remained low due to inadequate rainfall and pest attacks in the first quarter of 2018. Per Agricultural productivity reports, maize production, Malawi's staple food, was 15 percent below the country's five-year average and 19 percent below last year's output, severely threating Malawi's food security, hampering progress towards SDG 2 on 'Zero Hunger' and threatening the health status of the population, particularly of vulnerable children and pregnant women. As a result, 3.3 million people required food assistance to cover the food requirements for the 2018/19 lean season.

Table 1: Food Insecure population in Malawi – 2008/09 to 2018/19

Consumption Year	Food Insecure Population	% of total rural population
2008/09	613,291	5%
2009/10	275,168	2%
2010/11	508,089	4%
2011/12	272,500	2%
2012/13	1,972,993	13%
2013/14	1,855,183	12%
2014/15	695,600	4%
2015/16	2,833,212	17%
2016/17	6,692,114	39%
2017/18	1,043,000	7%
2018/19	3,306,405	22%

Forecasts for the 2018/19 growing, which runs from November 2018 until March 2019, remained pessimistic in view of the highly potential El Nino weather event in Southern Africa which projected at >75% chance with Malawi being among the highest at risk of being impacted. If the El Niño does prevail it will likely have negative impacts on staple food availability and access thus further worsening the situation of the affected population especially women and children.

Additionally, flooding affected several districts including Lilongwe and Nkhatabay, Rumphi, Phalombe, Karonga and Salima with Karonga being the most affected. Per the initial assessment conducted by

the Karonga District Civil Protection Committee, approximately 4,069 people comprising of 816 households (587 male headed, and 231 females headed households including 157 under-five children, 133 elderly people, 66 physically challenged persons. The displaced population sought refuge in designated temporary shelter sites while others were hosted in relatives/ neighbours' homes.

The country also experienced a cholera outbreak which started on the 24th of November 2017. The first three index cases were inhabitants of Iponga in Karonga district, who are traders by occupation and were returning from Tanzania after a brief stay. It is assumed that they contracted the illness while in Tanzania, where an outbreak of cholera was declared. Since then, the outbreak progressed along the shorelines affecting 939 people, of which 32 died. The last case of cholera in this season was recorded in Chikwawa district on 08 July 2018.

The table below shows cases of cholera disaggregated by person, place and time.

Table 2: Cholera Cases and Deaths (24 November 2017 to 08 July 2018)

District	**Outbreak Period**		**Total Cases**	**Total Deaths**	**Case Fatality Rate (CFR)**	**Cases by age and sex**				**Deaths by age and sex**			
	Start Date	End Date				**M**	**F**	**<5**	**5+**	**M**	**F**	**<5**	**5+**
Blantyre	25-Jan-18	25-Jan-18	1				1		1				
Chikwawa	10-Jan-18	8-Jul-18	2				2		2				
Dedza	10-Feb-18	7-Mar-18	31	1	3.2%	17	14	4	27		1		1
Dowa	14-Dec-17	6-Feb-18	5			3	2		5				
Karonga	24-Nov-17	21-Mar-18	347	7	2.0%	181	166	32	315	4	3	1	6
Kasungu	10-Dec-17	10-Dec-17	1				1		1				
Likoma	19-Jan-18	18-Feb-18	13			2	11	2	11				
Lilongwe	29-Dec-17	27-Apr-18	388	18	4.6%	195	193	42	346	8	10	1	17
Mulanje	23-Jan-18	28-Jan-18	4				4		4				
Nkhatabay	25-Dec-17	21-Jan-18	20			16	4	4	16				
Nsanje	22-Jan-18	30-Jan-18	6			4	2	5	1				
Rumphi	26-Jan-18	16-Mar-18	13			4	9		13				
Salima	4-Jan-18	27-Jun-18	108	6	5.6%	55	53	9	99	4	2	1	5
		TOTALS	***939***	***32***	***3.41%***	***477***	***462***	***98***	***841***	***16***	***16***	***3***	***29***

2.0 Humanitarian Results

2.1 Results Table

The results table below presents a snapshot of UNICEF-supported results against the targets set by the Country Office for the year 2018 and results achieved at cluster level for the clusters that UNICEF co-leads.

Table 2: results achieved by UNICEF and clusters in 2018

Indicators	Cluster/ Sector 2018 Target	Cluster/ Sector total results	UNICEF 2018 Target	UNICEF Total results
WATER, SANITATION & HYGIENE				
Internally displaced persons and host community members, cholera and drought affected persons, provided with safe water per agreed standards	208,330	1,294,387	125,000	351,599
People in humanitarian situations receiving critical WASH related hygiene promotion messages and interventions to prevent water borne diseases particularly cholera and diarrhoea	2,210,870	1,011,565	1,794,870	658,508
EDUCATION				
Children provided with access to quality education services	56,000	15,948	22,500	16,769
Adolescents who are in and out of school accessing relevant alternative education services	8,000	7,904	7,500	8,290
HEALTH				
Children immunized for measles			247,500	220,585
Children and women in humanitarian situations provided with access to health care services			230,410	212,308
NUTRITION				
Children under 5 years old with severe acute malnutrition admitted into therapeutic feeding programme	50,644	45,085	50,644	45,085
Children aged 6 to 59 months provided with Vitamin A supplementation	166,880	166,880	166,880	166,880
CHILD PROTECTION				
Children provided with access to safe access to community spaces for socialization, play and learning	80,000	233,411	80,000	233,411
No. of new reported cases of violence against children	8,000	8,548	8,000	8,548
HIV and AIDS				
Women retained on HIV treatment at six months	15,000	7,541		
SOCIAL PROTECTION				
Vulnerable households receive an emergency top-up through the social protection system			3,092	3,089

Results are achieved through contributions against appeals, as well as resources from UNICEF's regular programmes where necessary.

2.2 Results by programme area

2.2.1 Nutrition

In 2018, a total of 45,085 children (21,408M, 23,677F) children aged 6 to 59 months with Severe Acute Malnutrition (SAM) were admitted and treated through the Community-based Management of Acute Malnutrition (CMAM) programme in all the 28 districts in Malawi as shown in figure 1 below. This represents 89% of the 50, 644 SAM children targeted to be admitted in the CMAM program in 2018. The target of 50,644 was set based on the June 2017 Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey results which reported a higher SAM prevalence (0.3%) compared to the February 2018 SMART survey results (0.1%). The government through the Director of Nutrition recommended not to use the February 2018 SMART survey results for calculation of the 2018 SAM caseloads because the country projected increased levels of food insecurity during the second half of 2018, due to dry spells as well as the devastating attack of the fall army worm which destroyed maize crops in most parts of the country during the 2017/2018 agriculture season.

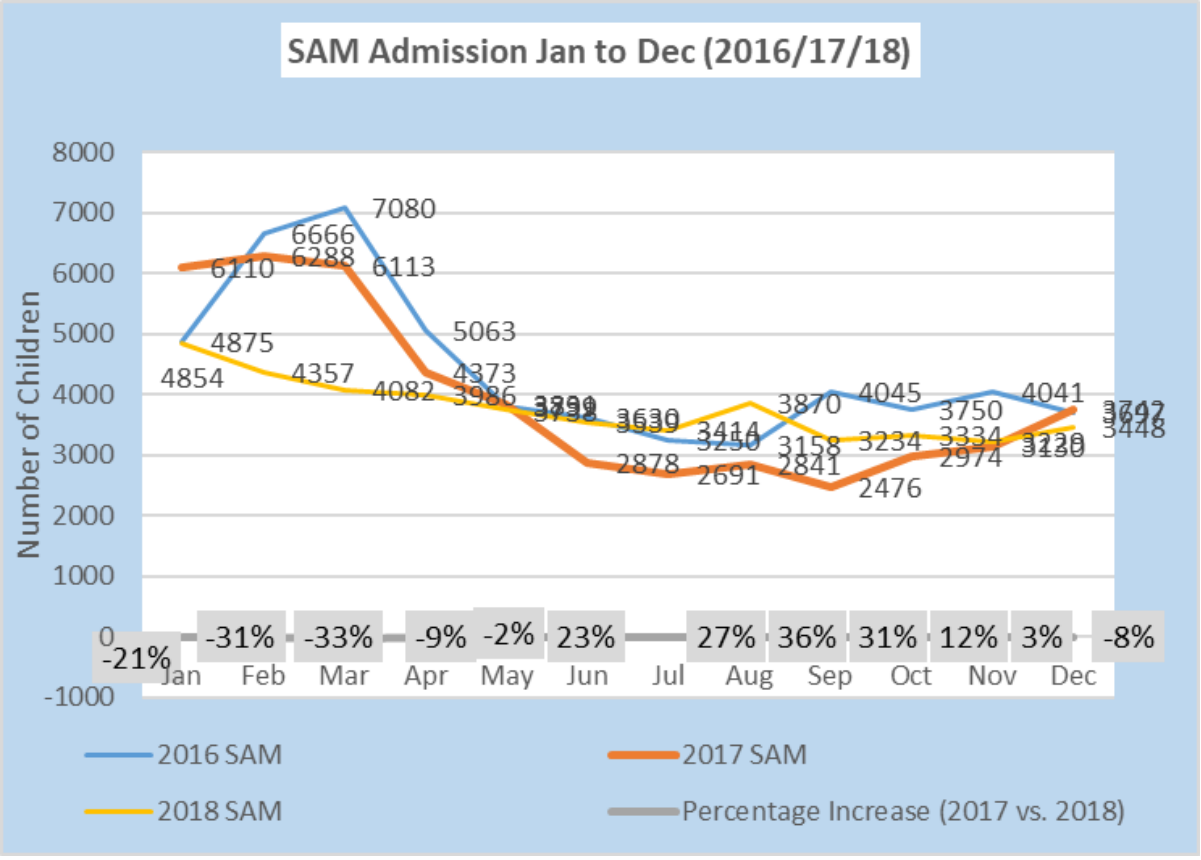


Figure 1: SAM Admissions Trends January – December 2016/2017/2018

During the same period, the lives of 40,729 (93.7%) children aged 6 to 59 months with severe acute malnutrition (SAM) who were admitted to CMAM program were saved, 972 (2.2%) died, 1,085 (2.5%) defaulted from the program while 695 (1.6 %) did not respond to nutrition treatment and were referred for further investigations. These program performance indicators were all within the internationally agreed minimum SPHERE standards[2] as shown in figures 2 – 4 below.

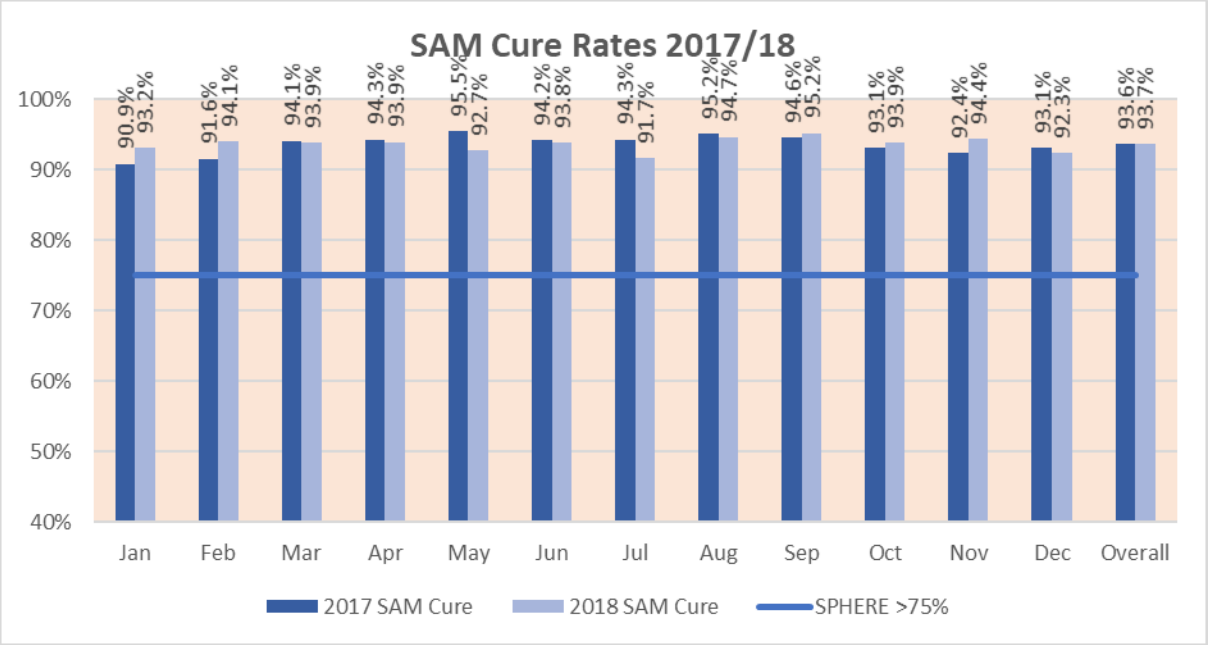


Figure 2: SAM Cure Rates January – December 2017/2018

[2] Cure rate above 75 per cent target, death rates below 10 per cent threshold and defaulter rates less than 15 per cent

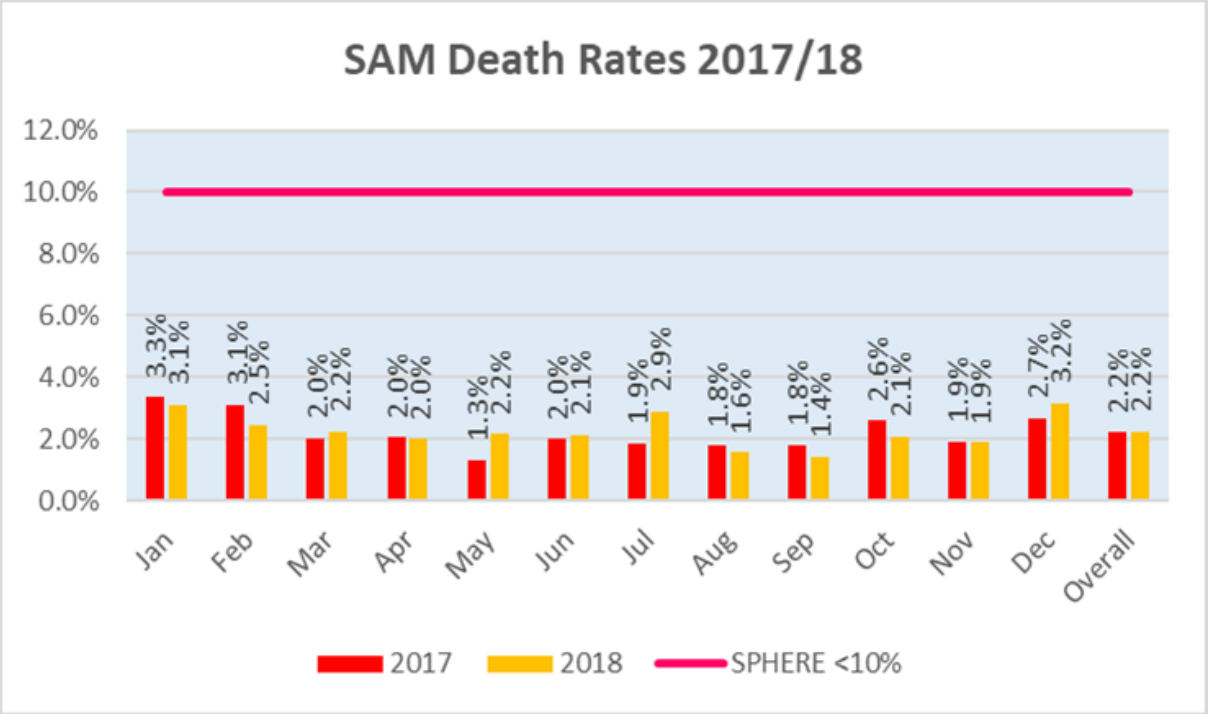


Figure 3: SAM Death Rates January – December 2017/2018

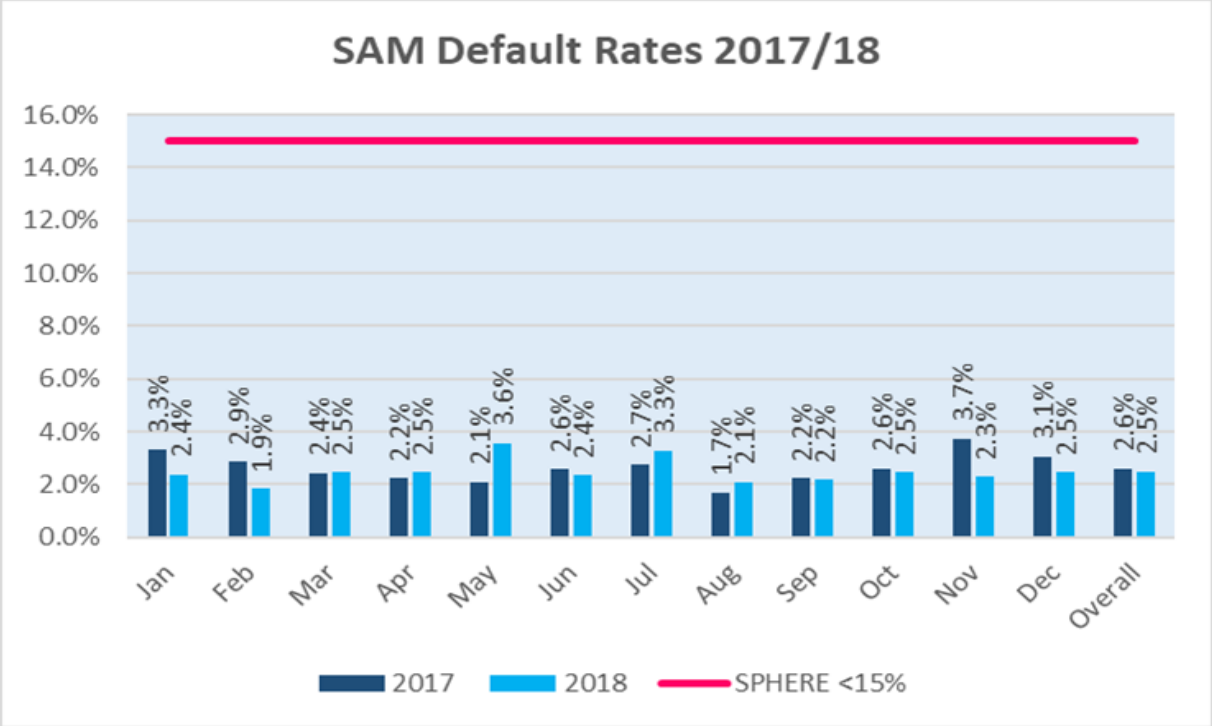


Figure 4: SAM Defaulter Rates January – December 2017/2018

UNICEF trained a total of 3,281 health workers to improve their knowledge and skills in quality management of both outpatient and inpatient care of SAM children in all the health facilities that were implementing the CMAM programme across the country. Additionally, 1,628 health workers across

59 NRUs had their skills improved in inpatient and outpatient SAM management through on-job coaching and mentorship support. A total of 2,763,388 (1,298,792M and 1,464,596F) children under five were screened for acute malnutrition, which contributed to the 45,085 children being admitted for SAM treatment.

Through system strengthening support, therapeutic nutrition supplies are integrated within the national supply chain management system and reporting is being done through the Logistics Management Information Systems (LMIS). A total of 1,237 (594M, 643F) health workers, including nutritionists and pharmacy focal persons, in all health facilities in Malawi had their LMIS knowledge and skills improved, which has resulted in effective and efficient management of stocks at health facilities by the pharmacy department. This has improved accountability and management of health facility stocks resulting in no stock outs in 724 health facilities.

A total of 810,388 community members (551,042F, 259,346M), including 1,073 local leaders in five districts, acquired knowledge and skills in optimal Maternal Infant and Young Child Feeding (MIYCF) practices through behaviour change and communication interventions. In addition, 156 traditional healers gained knowledge in the causes and management of acute malnutrition and are encouraging their communities to adopt health seeking behaviours and positive nutrition practices.

UNICEF also provided technical support to the Department of Nutrition, HIV and AIDS (DNHA) in coordinating the Malawi nutrition cluster which resulted in timely contingency and response planning, adequate resources mobilization and effective implementation of quality treatment of children with SAM in humanitarian situation. UNICEF also collaborated with and provided technical and financial support to the Ministry of Health to successfully conduct a nutrition survey using the Standardized Monitoring and Assessment of Relief and Transitions (SMART) methodology in February 2018. This provided up to date data on the nutrition situation in the country. The data from the SMART survey was critical in informing the Integrated Food Security Phase Classification (IPC) analysis which was used by the Malawi Vulnerability Assessment Committee (MVAC) to project that 3,306,405 people would be in Integrated Food Security Phase Classification (IPC) phases 3 and 4 and would require humanitarian assistance ranging from 2 to 6 months from October 2018 to March 2019.

2.2.2 Health

UNICEF with financial support from DfID, provided financial, logistics and technical support in establishing and running the CTCs where cholera cases were admitted. UNICEF supported the establishment of 22 Cholera Treatment centres (CTCs) and provided their operating costs. To prevent the risk of gender-based violence, separate, well-lit service areas for females and males were provided in the CTCs. All CTCs had separate admission rooms for females and males. In cases where the CTCs were located at long distances from villages or health facilities with no in-patient catering, patient guardians were provided with spaces for cooking. Timely prepositioning and dispatch of items of supplies to affected areas also contributed to the effectiveness.

While collaborative efforts by UNICEF and partners helped to contain the outbreak, the number of deaths recorded was above the WHO threshold. A total of 32 deaths (20 facility and 12 community deaths) were registered bringing the facility Case Fatality Rate (CFR) to 2.13% against the WHO

threshold of 1%. A government led review of the cholera response attributed the high CFR to poor management by health workers despite adequate availability of drugs in all the CTCs. UNICEF also supported the revision of the cholera manual, preparation of rapid response teams and trained health workers on cholera case management as a way of supporting the improvement of cholera case management by the health workers. At the end of the outbreak, the MoH, UNICEF, and partners worked together to decommission the CTCs to ensure that tents, temporary latrines, reusable WASH infrastructures at CTCs were properly dismantled, cleaned, disinfected, and appropriately packed in preparation for the next season of cholera.

220,585 children under the age of five in humanitarian situations were immunized against measles achieving 89% of the annual plan. Furthermore, 212,308 women and children in humanitarian context were reached with quality health services including treatment of diarrhoea, pneumonia, and malaria in flood prone districts of Malawi achieving 92% of the annual plan.

To support the health sector lifesaving interventions UNICEF worked in close collaboration with national and international NGOs, and WHO, under the leadership of the MoH at national district levels. For the provision of supplies for treatment of cholera patients, UNICEF partnered with Management Sciences for Health and MoH who ensured timely delivery of the supplies to the CTCs.

2.2.3 WASH

The 2018 WASH Sector response to emergencies involved the provision of safe drinking water, promotion of sanitation and hygiene among cholera affected communities and some few areas that experienced some flooding.

Over 350,000 people were provided with safe water through several means including drilling of 37 new water points, rehabilitation of 5 existing non-functional water points; undertaking trucking of water to some urban cholera affected communities not served by water utilities as well as conducting house hold water treatment using HTH 1% stock solution and water guard at family level among 44,300 households in the various affected districts.

Over 300,000 people (about 153,000 women and 147,000 men) gained access to sanitation facilities in cholera hot spots during the period of cholera out breaks in the affected districts. Over 1,359,473 people from the same areas had improved awareness about sanitation and hygiene.

These direct UNICEF results were achieved through closely working together with other partners within WASH cluster where emergency information was shared. UNICEF was able to respond based on gaps identified by the WASH cluster and even leverage other players to respond where UNICEF

could not reach. This is a key lesson for future responses in the country. The second lesson relates to cholera outbreak in the urban fringes of Lilongwe City where people don't have piped water and live in high density settlement that rely on pit latrines for sanitation which are close to hand dug wells where they get drinking water. Even few boreholes in these areas were found to be contaminated when tested and could not provide alternative safe source of water. The lesson that all stakeholders got during the response was the urgent nature of the need to provide lasting solution for the provision of safe water to these settlements. The water trucking that UNICEF funded and facilitated as a temporary measure during the cholera period had to be stopped because of its unsustainable costs; much to the displeasure of the beneficiaries. This triggered discussions with the city's water utility company (Water Board) and the ministry responsible who have promised the population to investigate their safe water needs as town dwellers and embark on sustainable solutions.

The long-standing challenge is the weak capacity of sub-national government structures to effectively and timely respond to emergencies. This is mainly due to limited resources to enable districts to undertake rapid action and sustain efforts before emergencies, at the onset of emergencies; as well as during and after emergencies without or with little external support. In fact, most of the government response is mainly limited to distribution of initial requirements of food and other non-food items (maize, blankets pails- in times of floods). The disease prevention efforts such as WASH needs are often left to external support. The partners assisting government also face challenges of mobilising adequate resources specially to build resilient communities in known emergency prone districts; each year partners run around these prone areas when in fact most of the emergencies in Malawi are to some extent predictable.

UNICEF worked with several partners to respond to the cholera outbreak including government ministries responsible for water and health, water boards, NGO partners, private social marketing firms; as well as local structures such as District Councils to contain the cholera outbreak that affected both rural and urban areas in 13 districts in Malawi. The Government and NGO partners concentrated on the service provision such as safe water provision including water treatment down to house hold level. The social marketing firms complemented efforts in hygiene promotion; the water board assisted in water trucking where it was required, and the district councils provided the much need frontline workers (extension field workers) to reach the beneficiaries. The WASH cluster provided the overall lead and coordination among all players.

2.2.4 Communications for Development (C4D)

With UNICEF support, 3 million people were empowered with cholera messages through cholera programmes, radio drama, and TV/radio spots/jingles and on 3 national and 16 community TV and radio stations and print media. Furthermore, over 856,337 people and 14,400 households were engaged through interpersonal channels including 464 community dialogues with community cinema, 12 road shows, door to door visits, and 305 theatres for Development and obtained information and call for actions to prevent and mitigate the spread of cholera in 19 cholera prone districts. UNICEF implemented this action under a branded communications campaigns called "Tithane ndi Kolera" (Let's End Cholera) campaign, partnering with the Centre for Development Communications (CDC), Malawi Red Cross (MRC), Parent and Child Health Initiative (PACHI), Story Workshop Education Trust.

The capacity and capability of 10 District Social Mobilization Committees (DSMC) comprising members (41 female and 101 male) was strengthened and they lead coordination and integration of C4D programmes to address harmful social norms and practices on cholera prevention. For instance, the DSMCs mainstreamed and harmonized NGO and media led C4D interventions, including messages and channels to reach and engage most vulnerable communities at risk of cholera under a branded integrated communications campaigns called "Tithane ndi Kolera" (Let's End Cholera).

Results of the door to door behavioural tracking exercise and exposure to the C4D cholera prevention and response interventions revealed that respondents from the eastern and southern regions had more access to cholera prevention interventions than the other two regions. There were a wide range of activities conducted by different organizations e.g. HSA meetings, house to house visits, road shows, distribution of IEC materials, community drama etc. Although there were some small variations between regions, the most frequent mentioned activities were HSA meetings (56.7%), community dialogues (20.9%) and house to house visits (18.8%). In terms of primary source of information on cholera, the community health worker was at the top of the list mentioned by 61.9% of the respondents followed by the hospital (24.7%) and the radio (13.2%). Although the percentages were low, but the common messages were encouraging the practice of washing hands at critical times (43.1%), use toilet for faecal disposal (40.2%). The least disseminated message was a need to continue breast feeding even when the baby has diarrhoea (8.5%).

In urban settings, 23 Bwalo's forums generated evidence to influence the cholera outbreak, identified 13 social accountability issues in health, WASH and harmful practices in to prevent spread of cholera in 6 hot spot areas of Lilongwe. Communities demanded quality services and took decisive actions, including cleaning of markets, inspection of households for availability of toilets and waste pits, removal of waste in undesignated places and general hygiene.

2.2.5 Education

UNICEF provided 16,769 children with access to quality education services through provision of temporarily learning spaces such as tents, tarpaulins and rehabilitation of schools. School in a box and recreation materials were also provided to children at Luwani refugee camp primary school. The school which had enrolment of 1,239 children, of which 620 were Mozambicans. At least 12 volunteer teachers were supported by UNICEF to provide psychosocial support and supplemental teaching and learning materials.

UNICEF, through the Living School Yard Transformation project, supported tree planting and school gardens in 70 schools. Trees act as a wind break which helps to prevent roofs from blowing off. This program is benefiting 17,250 learners in Dedza, Machinga, Nkhotakota and Chikwawa districts. In this project, UNICEF supported deployment of 70 volunteer teachers to assist in the implementation and support teaching at schools.

In addition, 8,290 out of school adolescents were provided with relevant alternative education services through functional literacy and Complementary Basic Education. At Luwani refugee camp, at least 350 refugee children were enrolled in the Complimentary Basic Education programme.

UNICEF also strengthened coordination of Education in Emergency, both at national and district level, through the recruitment of two cluster coordinators who were working exclusively for the education cluster based at the Ministry of Education. Ten participants from the Education in Emergency cluster were supported to undertake training in Disaster Risk management. Finally, UNICEF supported the development of the draft Education in Emergency strategy which will guide the cluster to prepare and respond to emergencies.

2.1.7 Social protection

UNICEF with financial support from Irish Aid (IA) and in partnership with the Ministry of Gender, Children and Social Welfare (MoGCDSW), the Department of Economic, Planning and Development (EPD), the World Food Programme (WFP) and CARE supported the provision of humanitarian assistance to all SCTP beneficiaries in Balaka through SCTP structures known as the vertical expansion of the Social Cash Transfer Programme. The districts were identified as drought affected by the MVAC/IPC assessment, which projected that 83,295 people would be unable to meet their basic food needs between December 2017 and March 2018. In these affected TAs, the SCTP supported 26,141 individuals with small monthly allowances, among them approximately 143,000 children. These SCTP households were largely excluded from the MVAC food response at the community-based targeting stage, even though they needed additional assistance. Top-ups through Vertical Expansion mirrored the transfer values provided by the parallel humanitarian response, representing approximately 65 percent of the Food Basket during the lean season, with the average monthly top-up totalling 13,500 MWK per household. A total of 3,089 identified households (16,989 individuals and 9,000 children) benefitted from these top ups. The end line report of the vertical expansion pilot indicated that SCTP households that were provided with the top ups showed evidence of investing in livestock and improved food consumption during the period. The pilot also provided much needed evidence towards targeting for humanitarian programming and the future of shock sensitive social protection in Malawi. Anecdotal evidence suggests that there is a widespread feeling that communities themselves should target households for food assistance (e.g. as per JEFAP), including those who benefit already from social protection programmes. It provided a learning ground based on evidence on how to operationalize the Malawi National Social Support Policy (MNSSP) by allowing for social protection programs to be adaptable to allow for scalability to respond to a shock.

Beneficiaries in Balaka signing [illegible] books after receiving their cash transfer top ups

2.2.8 Child Protection

The year 2018 was headlined by food insecurity in Malawi. As a result, it was envisaged that protection concerns such as violence against women and children, including sexual violence would be high. In 2018 alone, a total of 28,555 victims of violence were supported by Community Victim Support Units (CVSUs). These included 54% children (15,479 child victims with 6,392 boys and 9,087 girls). Most of the children who sought help from CVSUs suffered neglect totalling 4,014 (2,196 girls and 1,818 boys) followed by emotional abuse at 3,762 (1,628 boys and 2,134 girls) and physical violence at 3,410 (1,385 boys and 2,025 girls). Sexual abuse cases comprised 15% of all child violence cases seen at CVSUs between January and December 2018 up from 6% reported in June 2018. Girls reported more than double the amount of sexual violence cases compared to boys (1,708 for girls and 702 for boys).

Protection activities being crosscutting in nature mainly focused on provision of technical support, coordination and advocacy to mainstream protection issues in various cluster's response to emergency. The objective was to reduce protection threats for affected populations, and to protect all vulnerable groups from violence, sexual violence, exploitation, abuse and neglect during the period of emergency and ensure that human rights are respected.

The specific objectives for the emergency interventions in 2018 were to:

1. To facilitate coordination of protection stakeholders
2. To support mechanisms for prevention and response to all forms of violence, GBV and sexual exploitation and abuse (SEA) through strengthening of community-based complaints mechanisms (CBCM)
3. To support access to protection services including psychosocial services in children's corners
4. To mainstream protection and GBV in other clusters

Coordination meetings amongst protection cluster members were called by the Ministry of Gender Children, Disability and Social Welfare who were the lead agency in protection cluster. A joint protection cluster response plan for 2018 was developed and disseminated to all stakeholders for implementation. In addition, the 28 districts in Malawi were supported to develop their district specific plans for responding to emergency situations. Joint assessments missions were also organized to districts that were affected by floods including Rumphi, Balaka, Machinga, Phalombe and Chikwawa. These led to the development of response plans which were recommended for implementation by protection cluster stakeholders.

UNICEF Child Protection is part of the protection cluster as a co-lead. The cluster is led by the Ministry of Gender, Children, Disability and Social Welfare. Specifically, UNICEF aim was to support coordination of protection interventions during food insecurity response at national and district levels, establishment of mechanisms for prevention and response to all forms of violence. This includes GBV and sexual exploitation and abuse (PSEA) through strengthening of community-based complaints mechanisms (CBCM), ensuring access to services for populations affected by food insecurity through strengthening referral and survivor assistance frameworks and mainstreaming protection and GBV in other clusters.

Regarding mechanisms to prevent and respond to violence, UNICEF supported work in one stop centres in 7 districts in the country where there are standalone units within health facilities for management of physical and sexual violence. Through a partnership with Fountain of Life, trauma counsellor volunteers were deployed to the 7 one stop centres for support to victims of violence especially sexual violence. Awareness activities were also implemented to encourage survivors of violence to seek services in the one stop centres.

A total of 719 survivors of violence were assisted at One Stop Centres (OSC) in Blantyre, Zomba, Mulanje, Lilongwe, Nkhatabay, Mangochi and Mzuzu. Of these, 96% (n=692) were females and 4% males (see Figure 2 below). The OSC provided integrated, multi-disciplinary services in one physical location to survivors of violence, especially sexual and physical abuse. OSC in Malawi are standalone units within health facilities and house health, social, police and justice services. The form of violence most frequently reported at OSC during the reporting period was sexual violence (54%), followed by physical violence (46%) (see Figure 3 below)[3]. This echoes previous trends.

Figure 2: OSC caseload, by gender (2018)

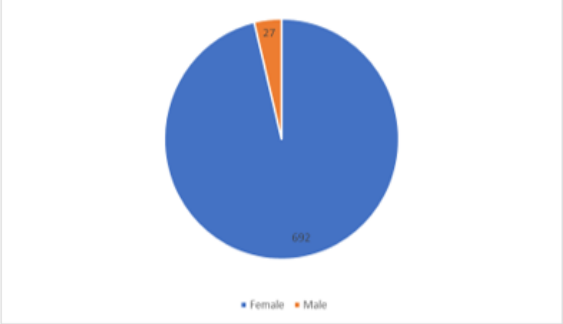
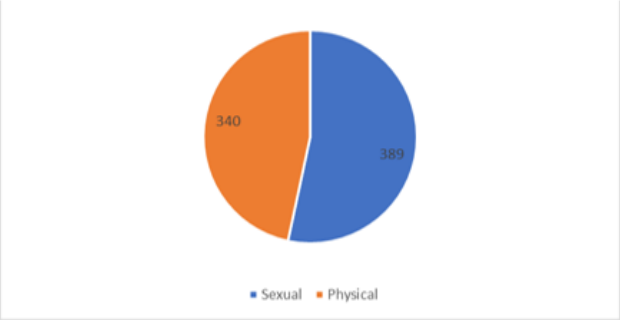


Figure 3: OSC caseload, by type of violence (2018)



The majority of cases reported at OSCs were referred from the Malawi Police Service (82%) followed by self-reporting (8%) and mothers (6%). In this regard, the Malawi Police Services was also supported to strengthen its child protection and community policing initiatives which provide support to those affected by various emergencies in Malawi. This was mainly done through monitoring of ongoing activities and mentoring of police child protection workers and community policing coordinators. In 12 emergency affected districts, the mentorship exercise involved linking police services with the wider community-based complaints mechanisms for ease of referrals. Review meetings were also organised for experience sharing among police child protection officers and community policing coordinators. A study on management of defilement cases also carried out by the Malawi Police Service and its findings disseminated to senior police management for adoption of recommendations.

In 2018 UNICEF procured 350 children's corners kits for facilitated play activities for children between 6 and 18 years. At these centres, children are engaged in various play and educational support activities with the aim of helping them cope with the various challenges that they may be going through in their homes. The 350 kits, which were distributed early in 2019 would benefit 3,500 children. Support was also provided to Ministry of Gender, Children, Disability and Social Welfare to

[3] Some survivors experienced more than one type of violence

finalise development of the PSS Guidelines in Emergencies for use by Community Child Protection Workers.

In addition to supporting children in children's corners, UNICEF also supported the reintegration of children from child care institutions back to their families. In Malawi, the main driver for sending children to child care institutions is poverty. UNICEF therefore supported social welfare offices with assessment of these children and support towards their reintegration back into their families.

To ensure that other clusters such as health, nutrition, education and WASH, GBV were mainstreamed in the emergency response, orientation of district protection committees on community-based complaints mechanisms and referral pathways were conducted in 6 districts of Rumphi, Mzuzu, Kasungu, Lilongwe, Chikwawa and Phalombe.

2.3 Results Achieved from Humanitarian Thematic Funding

The Humanitarian Thematic funding in 2018, UNICEF supported protection services. The thematic funds enabled continuous engagement with partners such as the Malawi Police Service, Ministry of Gender, Children, Disability and Social Welfare who were able to persistently raise awareness on violence on women and children, more so in emergency context resulting in an increased caseload registered at child protection service points including police victim support units, community victim support units, children's corners and one stop centres. Police victims support units and community child protection workers were also supported on management of information through mobile data platforms. Over 312,909 children between the ages of 3-6 attended services in children's corners where psychosocial support was provided through facilitated play activities.

Concerning response to violence, 7,921 new cases were recorded in 34 police victim support units across the country. These were provided services such as counselling, mediation and referral to other services such as courts and hospitals. A total of 211 children (114 boys and 97 girls) were reintegrated from child care institutions back to their communities. Of these 130 were reintegrated into extended families and 62 into biological families and 9 into foster families.

The thematic funds also enabled UNICEF to reach a total of 6,233 (2,959M, 3,274F) children aged 6 to 59 months with Severe Acute Malnutrition (SAM) and medical complications contributing 14% of the total SAM admissions for 2018. Out of the 6,233 admissions, the lives of 5,025 children (80.6%) were saved after successfully recovering from SAM with underlying medical complications, 529 (8.5%) died, 139 (2.2 percent) defaulted from the program and 219 (3.5%) did not respond to treatment and were referred for further investigations.

The thematic support also contributed to the training of 30% of the 1,628 health workers from all the NRUs. This resulted in improved knowledge and skills of health workers in in-patient management of SAM with other medical complications through on-job coaching and mentorship. These efforts contributed to improved performance of the Community Management of Acute Malnutrition (CMAM) program, as shown by the performance indicators that are within the minimum international SPHERE standards.

UNICEF also provided technical and logistical support to districts in ensuring timely CMAM data collection, consolidation, reporting, stock monitoring and tracking. UNICEF also supported front line health workers to follow up on defaulters, identify and refer children with acute malnutrition for appropriate treatment. In addition, a real-time SMS based stock monitoring system was developed and rolled out. These efforts resulted in 100% of the facilities reporting CMAM data before the 10th of every month and all facilities reporting no stock outs.

In the WASH sector, over 50,000 people were reached with safe water directly through thematic funding during the year through construction of up to 21 new water points and through provision of water treatment chemicals (water guard) at house hold level. Over 100,000 people were reached with hygiene messages in the emergency prone districts. The funding also assisted in the provision of other cholera prevention supplies such as plastic sheeting, buckets, soap and related supplies. Furthermore, the thematic funding assisted in providing capacity for UNICEF to deploy staff to respond to the cholera emergency by getting on board three temporary WASH staff members in form of technical assistance, who worked on coordination with other partners; who conducted extensive and intensive follow up field visits much needed to urgently and effectively respond to emergencies like cholera and floods. As a result, the cholera outbreak was effectively brought to a halt. Coordination through the WASH cluster for which UNICEF co-led with Government assisted in leveraging efforts of others to intervene where UNICEF support could not reach as there were as many as 19 cholera affected districts during the year.

In the Health Sector thematic funding was accessed during the initial stages of the outbreak in late 2017 and early 2018. The resources were used to procure cholera beds, Acute Watery Diarrhoea Kits, Methylated Spirits, cotton wools and infection prevention supplies including gumboots, apron and gloves. The resources were also critical during the initial stages of the response after conducting assessment of the affected areas and ensured faster delivery of assistance to meet the time-critical needs. The supplies procured provided relief for more than 350 cases of cholera and prevented the spread of the disease from affecting more than 15,000 people who were in immediate risk of contracting cholera in Karonga and NkhataBay districts.

The following CTC supplies were procured in the initial stages of the response

Description	Quantity
Solar Lamps	217
Diarrhoeal Disease Sets	4
Cholera bed	200.
GUMBOOTS BLACK (SIZE 7)- PAIRS	50
GUMBOOTS BLACK (SIZE 8) - PAIRS	50
GUMBOOTS BLACK (SIZE 6)- PAIRS	30
Methylated spirit, bottle	550
Cotton wool, 100g	124

An Oral Cholera Vaccine (OCV) campaign in Karonga district was monitored during the response. The OCV was staged in response to the outbreak as reactive OCV campaign. More than 108,000 people in the affected communities were reached with two rounds of OCV.

3.0 Assessment, Monitoring and Evaluation

In 2018, UNICEF Malawi established and maintained a data-driven humanitarian performance tracking tool which supported monitoring of performance against set targets. Snapshots of the monthly achievements were presented at monthly meetings of the Emergency Management Team and discussions were held which aided decision making in addressing the identified challenges.

UNICEF also conducted field visits to monitor the situation on the ground which ensured strong quality of the humanitarian response interventions on the ground as well as steady progress.

Furthermore, for the cholera response UNICEF undertook lessons learnt exercise which documented lessons and best practices learnt from the 2017/18 cholera response and made recommendations on how integrate the best practices, mechanisms and systems into future emergency preparedness and response efforts.

The UNICEF Malawi Emergency Management Team (EMT) was active throughout 2018 and held meetings at least once every month as a way of ensuring internal coordination and oversight during the response. UNICEF also actively participated in meetings of the Humanitarian Country Team as well as meetings of the national level clusters as well as inter cluster coordination meetings.

4.0 Financial Analysis

In 2018 UNICEF Malawi had carry over thematic funds amounting to USD755,338. An additional amount of USD613,195 was received from USAID/Food for Peace for nutrition sector in response to food insecurity. Critical areas of Protection, Education and HIV remained unfunded during the reporting period. UNICEF Malawi will continue to prioritise these areas for resource mobilization to mitigate and address the needs of women and children in emergencies.

2018 Funding Status against the Appeal by Sector (Revenue in USD):

Sector	Requirements	Funds Available Against Appeal as of 31 December 2018*		Funding Gap	
		Funds Received in 2018	Carry-Over	Amount	%
Nutrition	6,709,351	613,195	0	6,096,156	91%
Health	1,900,000	0	227,531	1,900,000	100%
Water, Sanitation & Hygiene	1,060,000	0	0	1,060,000	100%
Child Protection	340,000	0	0	340,000	100%
Education	300,000	0	0	300,000	100%
HIV & AIDS	160,000	0	0	160,000	100%
Social Protection	408,000	0	0	408,000	100%
Cross sectoral	**0**	**0**	**527,807**	0	
Total	**10,877,351**	**613,195**	**755,338**	**10,264,156**	**94.36%**

**Funds available includes funds received against current appeal and carry-forward from previous year.*

Table 4 - Funding Received and Available by 31 December 2018 by Donor and Funding type (in USD)

Donor Name/Type of funding	Programme Budget Allotment reference	Overall Amount*
I. Humanitarian funds received in 2018		
a) Thematic Humanitarian Funds (Paste Programmable Amount from Table 3)		
See details in Table 3		0
b) Non-Thematic Humanitarian Funds (List individually all non-Thematic emergency funding received in 2018 per donor in descending order)		
USAID/Food for Peace	SM/16/0590	613,195
Total Non-Thematic Humanitarian Funds		**613,195**
c) Pooled Funding **(i) CERF Grants** (Put one figure representing total CERF contributions received in 2018 through OCHA and list the grants below) **(ii) Other Pooled funds** - including Common Humanitarian Fund (CHF), Humanitarian Response Funds, Emergency Response Funds, UN Trust Fund for Human Security, Country-based Pooled Funds etc. (Put the figure representing total contributions received in 2018 through these various pooled funding mechanisms.)		
CERF		
Humanitarian Response Fund		
d) Other types of humanitarian funds		
Total humanitarian funds received in 2018 (a+b+c+d)		**613,195**
II. Carry-over of humanitarian funds available in 2018		
e) Carry over Thematic Humanitarian Funds		
Thematic Humanitarian Funds	SM/14/9910	**755,338**
f) Carry-over of non-Thematic Humanitarian Funds (List by donor, grant and programmable amount being carried forward from prior year(s) if applicable)		
Total carry-over non-Thematic Humanitarian Funds		
Total carry-over humanitarian funds (e + f)		**755,338**
III. Other sources (Regular Resources set -aside, diversion of RR - if applicable)		
Total other resources		

** Programmable amounts of donor contributions, excluding recovery cost.*

***** 2018 loans have not been waived; Cos***

5.0 Future Work Plan

UNICEF's strategy will continue to be delivered through both sectoral and intersectoral responses in nutrition, child protection, education, health, social protection and WASH supported by communication and community engagement activities.

To respond to any rapid onset crisis in a timely manner, UNICEF will continue to preposition stocks in strategically located warehouses. These include tents, school-in-a box, recreation kits, early childhood development kits, water treatment chemicals, buckets, soap, plastic sheeting, and cholera kits as well as beds. These supplies are used to provide immediate assistance to the affected people, based on requests from the Malawi Government and other partners.

To reach out to food insecure vulnerable women and children, UNICEF will pilot provision of cash top ups to households with malnourished children, PLW and HIV and members identified through health centres in food insecure Mangochi district to mitigate the risk of them sharing the nutrition support they receive through health centres i.e. Corn Soy Blends, Ready to Use Therapeutic Foods. The project is being implemented bearing in mind on observations from previous food insecurity response efforts including that of evidence of ration dilution (sharing of therapeutic foods) mainly OTP/SFP commodities at HH level.

As a way of supporting the improvement of cholera case management by the health workers UNICEF is planning to support the revision of the cholera manual, preparation of rapid response teams and training of health workers on cholera case management.

Below were the planned programme targets for 2018:

Nutrition

- 57,381 children aged 6-59 months affected by severe acute malnutrition, admitted into treatment
- 400,075 Children aged 6 to 59 months provided with Vitamin A supplementation

Health

- 247,500 children in emergency affected areas immunized for measles
- 230,410 children and women in humanitarian situations provided with access to health care services

WASH

- 495,960 people affected by drought, floods and cholera (including approximately 262,858 children) provided with safe water per agreed standards
- 495,960 people reached with key messages on hygiene practices

Child Protection

- 300,000 children with access to safe community spaces
- 1,000 identified survivors of sexual violence provided with a comprehensive response

Education

- 18,000 school-aged children including adolescents gain access to quality education services
- 2,000 in and out of school adolescents gain access to relevant alternative education services

Social Protection

- 14,500 vulnerable households receive cash emergency top ups

6.0 Expression of Thanks

UNICEF wishes to express its sincere gratitude to all partners whose support has been critical in maintaining and scaling up the emergency response efforts as the country continues to experience disaster situations that affect the lives and livelihoods of the affected populations. The contribution received from USAID/Food for Peace in 2018 and carry over thematic contributions from German Committee for UNICEF, Japan Committee for UNICEF and United Kingdom Committee for UNICEF are particularly appreciated as they enabled UNICEF to respond quickly to needs of those affected.

UNICEF also appreciates and acknowledges the role of the Government of Malawi, CSO partners, collaborating international organizations and sister UN agencies, whose partnerships have been critical in achieving key results for children and women in Malawi humanitarian situations.

Annex 1 - Report Feedback Form

UNICEF is working to improve the quality of our reports and would highly appreciate your feedback. Kindly answer the questions below for the above-mentioned report. Thank you!

Please return the completed form back to UNICEF by email to:

Name : Roisin De Burca

Email : rdeburca@unicef.org

***

Title of Report/Project:

UNICEF Office:

Donor Partner:

Date:

SCORING:	**5 indicates "highest level of satisfaction" while**
	0 indicates "complete dissatisfaction"

To what extent did the narrative content of the report conform to your reporting expectations? (For example, the overall analysis and identification of challenges and solutions)

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what we missed or what we could do better next time?

To what extent did the fund utilization part of the report meet your reporting expectations?

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what we missed or what we could do better next time?

To what extent does the report meet your expectations about the analysis provided, including identification of difficulties and shortcomings as well as remedies to these?

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what we could do better next time?

To what extent does the report meet your expectations regarding reporting on results?

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what we missed or what we could do better next time?

Please provide us with your suggestions on how this report could be improved to meet your expectations.

Are there any other comments that you would like to share with us?

Thank you for filling this form!