UNICEF MALAWI

Sectoral Report for Nutrition for the period January to December 2018

A Mother with her child attending a theatre development training, as members of drama club in Dowa UNICEF Malawi/2018/Juana Sosa

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ABBREVIATIONS AND ACRONYMS

ANCC	Area nutrition coordination committee
CMAM	Community Management of Acute Malnutrition
CSO	Civil Society Organisation
DC	District Council
DHIS2	District Health Information System 2
DMECC	District Monitoring and Evaluation Coordination Committee
DMEO	District Monitoring and Evaluation Officer
DNCC	District Nutrition Coordination Committee
DNHA	Department of Nutrition HIV and AIDS
FAO	Food and Agriculture Organisation
HMIS	Health Management Information System
IEC	Information, Education and Communication
IYCF	Infant and Young Child Feeding
LUANAR	Lilongwe University of Agriculture and Natural Resources.
M&E	Monitoring and Evaluation
MDHS	Malawi Demographic Health Survey
MICS	Multiple Indicator Cluster Survey (MICS)
MNPs	Micronutrient Powders
MoH	Ministry of Health
NECs	Nutrition Education and Communication Strategy
NGO	Non-Governmental Organisation
NNIS	National Multi-Sector Nutrition Information System
NRU	Nutrition Rehabilitation Unit
OTP	Outpatient Therapeutic Programme
RUTF	Ready to Use Therapeutic Food
SDG	Sustainable Development Goals
SFP	Supplementary Feeding Programme
SMS	Short messages services
SUN	Scaling Up Nutrition
TOR	Terms of Reference
TWG	Technical Working Group
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
VNCC	Village Nutrition Coordination Committee
WFP	World Food Programme
WHO	World Health Organization

1. EXECUTIVE SUMMARY

The Department of Nutrition, HIV and AIDS (DNHA)'s capacity was improved in advocacy, coordinating evidence-based, equitable gender-sensitive nutrition policies and costed strategies resulting in finalization and dissemination of a National Multi-Sector Nutrition Policy, the Strategy (2018 - 2022) and the monitoring and evaluation framework. UNICEF collaborated with DNHA to engage with various stakeholders (government departments, donors, Civil Society Organisation (CSO), development partners, research and academic institutions) for the development of the National Strategic Plan for Adolescent Nutrition (2018 - 2022). This has helped in profiling the much-neglected nutritional issues of adolescents and enhanced leverage of resources for adolescent nutrition interventions in the country. UNICEF provided technical and financial support to DNHA to conduct the Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey to assess the prevalence of acute malnutrition in 2018. The overall prevalence of Global Acute Malnutrition (GAM) has decreased from 2.2 percent in 2017 to 1.3 percent in 2018. The prevalence of Severe Acute Malnutrition (SAM) has decreased from 0.3 percent in 2017 to 0.1 percent in 2018.

Institutional capacity for Ministry of Health (MoH) was enhanced to manage the treatment of Severe Acute Malnutrition (SAM), Micronutrient and Maternal and Infant Young Child Nutrition interventions resulted in improved quality of care for children. Equitable access to community management of acute malnutrition (CMAM) services increased during the reporting period from 722 facilities in December 2017 to 724 by December 2018 against the 731 targeted facilities, representing 99 percent national coverage. A total of 2,763,388 (1,298,792 male and 1,464,596 female) children under five were screened for acute malnutrition through active case finding, which contributed to 45,085 children (21,408 male, 23,677 female) being admitted and treated through the CMAM programme. Access to quality CMAM services among beneficiaries has sustained low SAM death rate within the recommended Sphere minimum standards of SAM treatment. This has been achieved through timely availability of life-saving nutrition supplies and other essential drugs and appropriately utilized in all the 724 health facilities. Therapeutic nutrition supplies have been integrated in the national supply chain management system which has improved accountability and management within Ministry of Health. These collective actions between UNICEF and MoH have contributed to saving lives of 28,378 children and improved performance of the CMAM program, as shown by the performance indicators being within the minimum Sphere standards (cure rate 93.0 percent against more than 75 percent Sphere standard) death rate 2.2 percent (less than 10 per cent Sphere standard) and defaulter rate 2.8 percent less than 15 percent).

There is now improved access to, and uptake of, maternal and infant young child nutrition services among caregivers in 15 targeted districts through social behavior change communication and community engagement. This is substantiated by the preliminary results from a sub-national survey indicating an upward trend in the rate of exclusive breastfeeding to 81 percent from 67 percent (Lot Quality Assurance Survey (LQAS), 2018). This is also higher than the national average for exclusive breastfeeding, which is at 61 percent (DHS 2015-16). Likewise, the provision of the Minimum Acceptable Diet (MAD) increased from 10.5 percent in 2017 to 14.4 percent[1] in 2018, which is also

[1] LQAS Survey 2018

higher than the national average, which is at 8 percent (DHS 2015-16). A total of 220,897 caregivers of children under two years received counselling on key child feeding and caring practices and 6,340 frontline workers (FLWs) in 15 target districts improved their knowledge and skills in optimal breastfeeding and complementary feeding; food fortification; integrated homestead farming; WASH; health; and monitoring and reporting. A total of 36,182 out of 50,000 (72 percent) households established backyard gardens and 73,362 out of 80,000 (92 percent) acquired small livestock, thereby increasing access to diversified diets for under-five children and women. A total of 118,402 out of 166,128 (71 percent) households have a hand washing facility with soap and 154,808 out of 166,128 (93 percent) households have a pit latrine.

A total of 2,166,940 children 6-59 months (1,029,447 male, 1,137,493 female) received Vitamin A capsules to improve their immunity against key childhood illnesses, representing 88 percent coverage; and 1,944,830 children 12-59 months (931,594 male, 1,013,237 female) were protected from intestinal worms with deworming tablets, representing 95 percent coverage during the first round in the reporting year. Through Salt Iodization Programme, there was improved access to iodized salt at market level in all the districts. This was evidenced by the routine fortification monitoring report 2018 which shows that 94 percent of salt at market level was iodized. All targeted districts were able to implement quality complementary feeding (CF) using point of use micronutrient powders (MNPs) and a total of 287,480 children (140,865M, 146,615F) received MNPs.

A National Multi-Sector Nutrition Information System (NNIS) was developed which resulted in improved planning, reporting, monitoring and informed decision making at all levels across sectors. Capacity of 118 district officials (Monitoring and Evaluation Officer, Senior Nutrition, HIV and AIDS Officer, key District Nutrition Coordination Committee (DNCC) members) from 28 districts to use the NNIS was enhanced, increasing the reporting rate from 21 percent (6/28 districts) in 2017 to 57 per cent (16/28 districts) in 2018. In addition, 28 evidence-based district quarterly action plans were developed, using data from performance reviews of key nutrition indicators. UNICEF in collaboration with the Ministry of Health developed an innovative real-time SMS based stock monitoring system which has improved districts capacity in monitoring Ready-to-Use Therapeutic Food (RUTF) in all 28 districts.

2. STRATEGIC CONTEXT

The Government of Malawi has shown high-level political commitment to address malnutrition as demonstrated in the current national development plan “Malawi Growth and Development Strategy-III 2017-22”. Nutrition has been recognized as one of the priority cross cutting areas which is prerequisite for human growth and development, and an integral element for the socio-economic development of the country. The MGDS III recognizes the importance of eliminating all forms of malnutrition as a crucial step for inclusive and sustained development in the country and calls for a renewed collective action and effective multi-sector coordination to meet the 2030 Agenda.

Recognizing the intrinsic linkage of hunger, malnutrition with poverty ultimately impeding the overall socio-economic development of the country, adequate nutrition is enshrined in the Constitution of Malawi. Malawi was an "Early Riser in joining the SUN Movement in early 2011 and since then, the government of Malawi has given top priority to address malnutrition using a multi-sectoral approach. In recent years, there has been concerted effort for creating an enabling environment for nutrition as evidenced by the development of conducive and coherent policies, strategies across relevant sectors for improved nutrition namely the development of the first National Nutrition Policy and Strategy in 2007 and now its successor policy, the National Multi-Sector Nutrition Policy 2018-22. Additionally, Malawi is in the final stages of the development of a Food and Nutrition Security Bill, an Agriculture Sector Food and Nutrition Strategy, and the second version of the Multi-Sectoral Nutrition Education and Communication Strategy (NECS) II.

Malawi has successfully reduced levels of stunting by 21 percent from 47.1 percent in 2010 to 37.1 percent in 2015 as shown in Figure 1. Infectious diseases, such as diarrhoea and poor dietary intake, as evidenced by the fact that only eight percent of children aged 6-23 months meet the minimum acceptable diet in Malawi (MDHS 2015/2016). Dietary intake and Diseases have been found to have the strongest association with various forms of malnutrition. These are manifested in low birth weight, stunting, underweight, wasting, iodine deficiency disorders and anaemia. Although Malawi has made some significant strides in reducing chronic malnutrition, stunting levels of 37 percent remain a major public concern, given the negative impact on children's growth and development, which endures through their life cycle, and the implications for the country's long-term development.

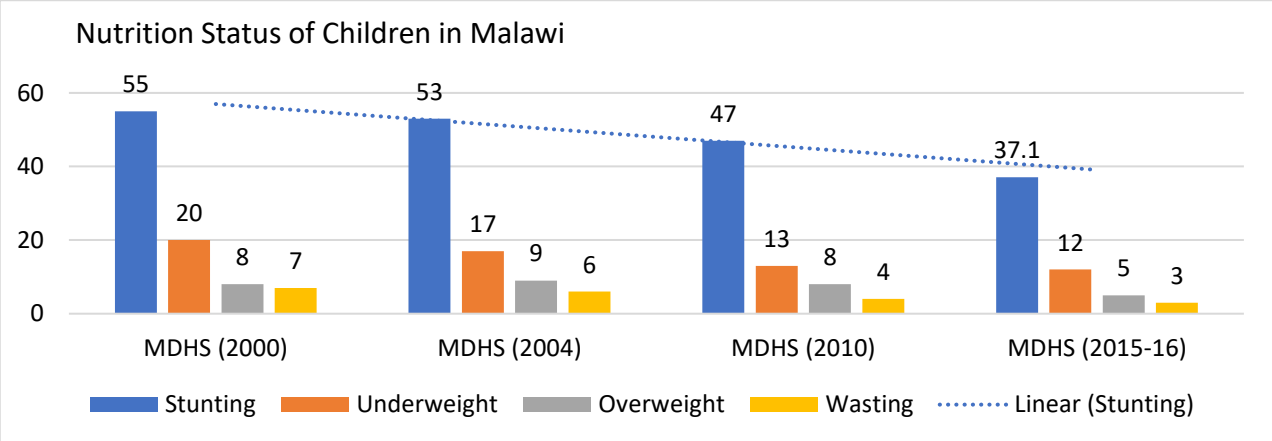

Figure 1: Trend in Nutrition Status of Children

In tackling child malnutrition in Malawi, UNICEF supported the authorities at national and district levels in working with families and communities on the prevention of stunting and improving understanding among parents, other caregivers and family members, and communities. This is done through awareness of the importance of nutrition, especially during the critical 1,000 days period covering conception, pregnancy and the first two years of the child's life[2]. UNICEF supported the establishment and development of policy frameworks, a community-based health and nutrition

[2] Malawi became one of the first members worldwide and the first in Africa of the Scaling UP Nutrition (SUN) Movement in 2011 that gives priority to evidence-based and cost-effective interventions to prevent and treat undernutrition.

strategy (that is integrated with other programming areas, such as WASH and ECD), and robust coordination mechanisms from national to community levels, including active Community Leaders Action Nutrition (CLANS) groups and community-based Care Groups for nutrition and multi-sectoral nutrition sensitive programming.

Wasting: Malawi has reduced wasting levels from seven percent in 2000 to three percent in 2015-2016.[3] In 2018, wasting levels were further reduced to 1.3 percent. A contributing factor over the past decade has been the scaling up of the Community Management of Acute Malnutrition (CMAM) programme and services by the MoH and Department of Nutrition, HIV and AIDS (DNHA). This has led to a 99 percent coverage rate (724 CMAM sites out of the 731 sites) throughout the country. UNICEF supports the key components of the CMAM program namely community outreach, active case finding, and out-patient and in-patient management of severe acute malnutrition (SAM) in these sites. With UNICEF support, the MoH conducted a bottleneck analysis with partners in 2014 that led to the development of the CMAM Operational Plan for 2017-2021, which complements the Health Sector Strategic Plan II. The CMAM Operational Plan supported the stakeholders for effective and efficient allocation and use of resources for CMAM activities at national and district levels. Communication for development (C4D) approaches were used that helped to increase demand for nutrition screening and SAM treatment, leading to more children with SAM receiving treatment in 2018 a total of 45,085, compared to 29,000 - 35,000 between 2011-2015.

Infant and Young Child Feeding: Inadequate infant and young child feeding (IYCF) practices contribute to acute and chronic malnutrition. The Malawi DHS 2015-2016 showed a digressing trend in exclusive breastfeeding as portrayed by Figure 2. Exclusive breastfeeding rates for the first six months of life declined from 71 percent in 2010 to 61 percent in 2015. The low quality of complementary feeding for children aged 6-23 months also shows a decline measured in the Minimum Acceptable Diet (MAD) of young children, dropping from 19 per cent in 2010 to eight per cent in 2015 as shown in Figure 3. These trends are generally associated with the lack of a sufficient variety of food at household level to introduce into children's diets for appropriate complementary feeding as well as low levels of education among adolescent girls and women of child bearing age, and socio-cultural behaviours.

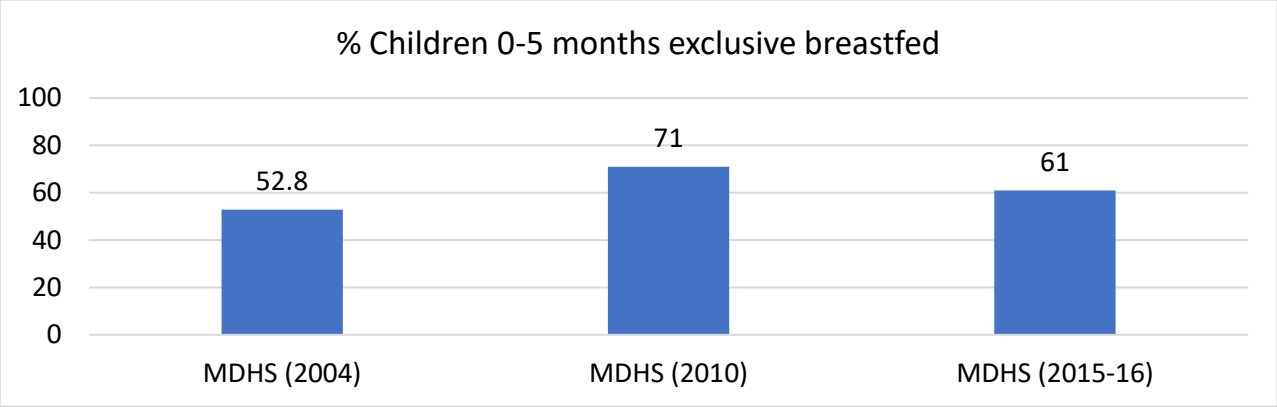

Figure 2 Trend in Exclusive Breastfeeding Practices

[3] MDHS, 2015-2016.

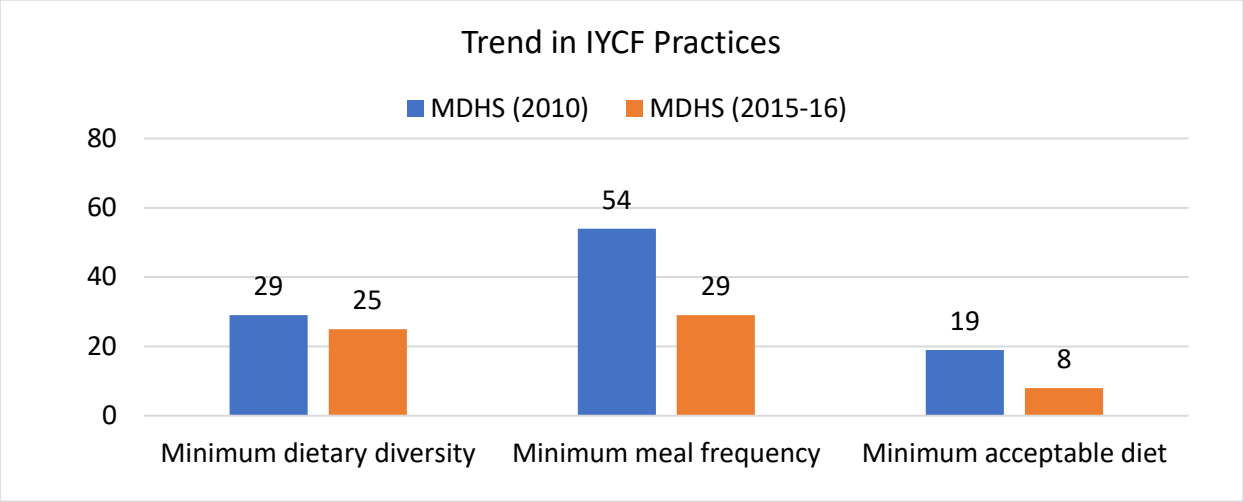

Figure 3 Trend in IYCF Practices among Children 6-23 months

Micronutrients: Malawi has substantially reduced vitamin A deficiency among children 6-59 months from 59 percent in 2001 to 4 percent in 2015-16 (Figure 4), which has been attributed to complementary micronutrient intervention strategies. While vitamin A deficiency is no longer a public health problem in Malawi, there remains an unacceptably high prevalence of anemia in women of child bearing age at 33 percent (Figure 5), pregnant women at 45 percent, adolescent girls at 35 percent and children 6-59 months at 63 percent.[4] Sixty percent of primary school children are zinc deficient[5], which means that this deficiency needs to be addressed in early childhood as well as the middle childhood years. Of concern, household consumption of iodized salt reduced from 95 percent in 2009 to 75 percent in 2015-2016.[6] For young children, if anemia (iron deficiency), and zinc and iodine deficiencies are not addressed, they can lead to impaired mental and cognitive development and function.

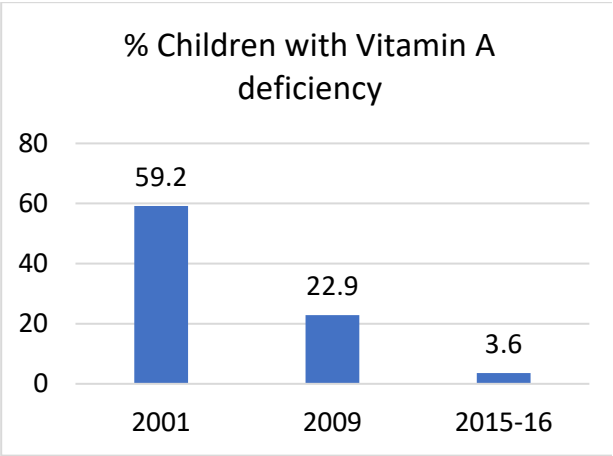

Figure 4 Trend in Vitamin-A deficiency

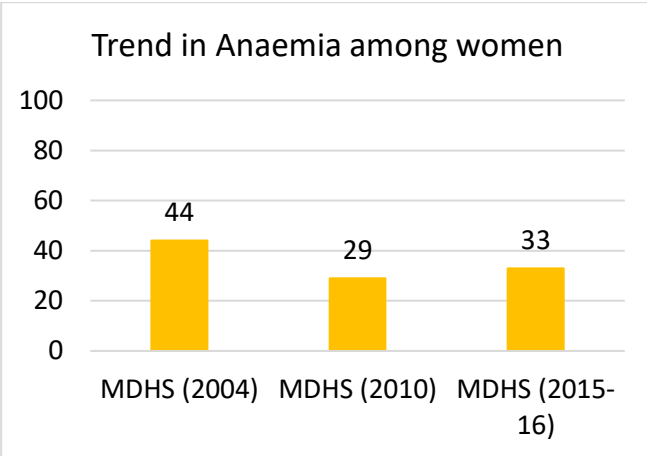

Figure 5 Trend in Anaemia status among women

[4] Malawi Micronutrient Survey (MMNS), 2015-2016 and Malawi Demographic Health Survey 2015-16
[5] Ibid.
[6] MMNS, 2009 and MMNS, 2015-2016.

CHALLENGES AND LESSONS LEARNED

The finalisation of Nutrition Education Communication Strategy (NECS) II awaits the stakeholders' validation. Inconsistency of participation by different stakeholders in finalisation of the strategy was identified as a bottleneck for this output however, UNICEF collaborated with DNHA and constantly engaged with stakeholders.

While the district reporting rate has increased for National Multi-Sector Nutrition Information System (NNIS), there are still gaps in district reporting. Additional efforts were made through supportive supervision visits and the identification of focal persons within the districts to coordinate the sectors and partners for reporting.

Inadequate capacity of health workers continued to be a major challenge in CMAM program. To address this challenge, a total of 3,281 health workers had their knowledge and skills improved in quality management of both outpatient and inpatient care of SAM children in all the health facilities 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.

Although the number of districts covered for MNPs has increased, the number of children reached remained low due to cultural beliefs and negative social norms. In response, UNICEF supported community mobilisation, advocacy and social mobilisation activities for uptake of MNPs among caregivers were intensified.

Membership of nutrition coordinating structures at both district and community-level comprise more male than female members in most districts. The power relations and social norms at the household level affect decision-making and access to resources leading to poor nutrition status for both women and children. To address gender disparities especially at community-level, Communication for Development (C4D) enhanced nutrition knowledge and skills among 2,832 chiefs (who are the custodians of culture), 2,434 religious leaders and 350 male champions to advocate for the adoption of positive nutrition behaviours and practices.

STRATEGIC PRIORITIES

The program has accelerated actions focusing on the first 1,000 days of life in vulnerable districts that have stunting levels that are higher than the national average as part of the Scaling Up Nutrition (SUN) movement. This included provision of supplies, technical assistance and community-focused C4D, focusing on nutritional care of pregnant women, exclusive breastfeeding promotion up to 6 months and continued breastfeeding for two years or more, together with safe, nutritionally adequate, age appropriate, responsive complementary feeding starting in the sixth month. Collaboration with other UN agencies (FAO and WFP) has also been sought to ensure that evidence-based nutrition sensitive interventions that address basic and underlying causes of stunting are implemented at scale using the care groups platform. During 2018, the UNICEF nutrition program had 5 focus areas:

Maternal Nutrition: With a focus on the first 1000 days, maternal nutrition was prioritized and ensured that pregnant women had improved access to antenatal care; iron and folate supplementation and information on nutrition key messages. Education and counseling of appropriate maternal care was also provided at facility and community levels.

Infant and Young Child Nutrition: Promotion, protection and support of optimal IYCF remains the focus at national, institutional and community levels. Scaling up Infant and Young Child feeding by expanding network of community workers was done to implement evidence-based IYCF community interventions. This includes community counselling and promotion, community outreach to improve contacts with households and expand demand for and coverage of IYCF services. There was also counselling and support on maternal nutrition during pregnancy and lactation at scale; improving quality of complementary feeding through home fortification and hygiene promotion.

Control of Micronutrient Deficiencies**:** Micronutrient interventions were implemented routinely through the health and community delivery system. This included provision of maternal, child micronutrient supplementation (Vitamin A, Iron and Folate); implementation of staple food fortification at scale including advocacy for point of use home fortification at scale; behavior change communication to promote consumption of micronutrient rich foods; and de-worming.

Management of Children with Severe Acute Malnutrition**:** UNICEF supported the quality delivery of CMAM services integrated with Integrated Management of Neonatal and Childhood Illness (IMNCI) at community levels, supply chain systems strengthening, and end user monitoring. Furthermore, building on the successes on the nutrition emergency response, community-based screening for acute malnutrition and growth promotion activities were implemented using the care groups, village clinics and outreach posts in the community. Children with acute malnutrition were referred to the health facility for further management. Support towards integration of SAM treatment commodities into the national Ministry of Health supply chain was done to ensure timely treatment and care of children with SAM.

Nutrition Information Systems strengthening**:** The program focused on strengthening the National Multi-Sector Nutrition Information System to improve the quality of overall nutrition program delivery and monitoring mechanisms, multi sectoral nutrition analysis and informed decision making across sectors. Data quality assessments, review meetings and capacity building on reporting and analysis were conducted as part of the quality assurance.

3. RESULTS ACHIEVED IN THE SECTOR

3.1 Output 1: The nutrition sector (DNHA) in Malawi has the capacity to coordinate evidence based, equitable gender sensitive legislations and costed strategic plans for scaling-up nutrition interventions by 2018

The capacity of DNHA improved in governance, coordination, monitoring and advocacy, as evidenced by the overall SUN process for Malawi which increased from 77 percent in 2017 to 78 per cent in 2018 (SUN Assessment Report 2018). The progress marker on coordination improved from 85 percent to 94 percent and sustained the progress for aligning actions for common results framework and financial tracking and resource mobilization at 75 percent and 69 percent respectively. The progress marker on coherent policy and legal frameworks decreased from 79 per cent to 75 percent, as the Food and Nutrition Bill is still waiting for full cabinet approval. High level advocacy and political commitment was established through the dissemination of 2018-2022 National Multi-Sector Nutrition Policy and the Strategy which was disseminated to nearly all the districts. A total of 532 government and non-government officers at national and district level had improved knowledge and skills in multi-sectoral nutrition planning and programming. So far seven district councils have incorporated nutrition issues affecting children and women in the District Development Plans (DDPs) in tandem with the Malawi Growth and Development Strategy III (MGDS III) and the 2018-2022 National Multi-Sectoral Nutrition Policy. This ensured the prioritization of nutrition programming and resource mobilization in the district. This was achieved through UNICEF technical and financial support to DNHA and District Councils which led to nutrition being incorporated in the District Development Plans (DDPs).

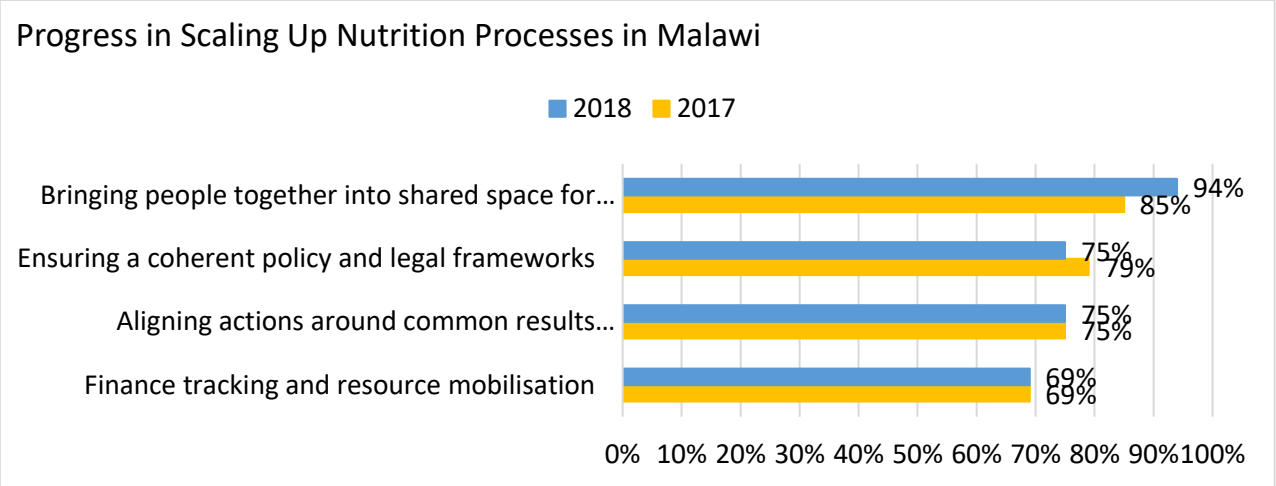

Figure 6 Progress in SUN Processes 2018 Vs 2017

Based on the results and lessons learnt during the implementation of 2011-16 NECS I, building on the results and outcomes of implementing the predecessor 2011-2016 NECS I am considering the existing and emerging issues in the country such as overnutrition and adolescent undernutrition, the 2018 – 2022, DNHA developed the National Nutrition Education and Communication Strategy (NECS) II 2019-23. This will also address both existing and emerging issues such as overnutrition and adolescent undernutrition. Emphasis in the strategy was placed on adolescent, maternal and infant and young child nutrition through community engagement and empowerment, institutional

capacity building and strengthening monitoring and evaluation at all levels. The strategy guides the implementation of the 2018-2022 National Multi-Sector Nutrition Policy priority area number 5 (Nutrition Education, Social Mobilization and Positive Behavior Change) which will address negative gender norms on adolescent nutrition.

The DNHA also developed, validated and finalized the 2019-2023 National Strategic Plan for Adolescent Nutrition through broad based participation from various key stakeholders in the country. This has helped in profiling the much-neglected nutritional issues of adolescents and enhanced leveraging of resources for adolescent nutrition interventions in the country. The strategic plan provided a framework and guidance for effective implementation of nutrition services to ensure improved nutrition among adolescents in Malawi. The Maternal, Infant and Young Child Nutrition (MIYCN) Strategy is being finalized. The strategy focuses on pre-pregnancy, pregnancy, birth, infancy, early childhood, adolescence and adulthood through greater knowledge, skills, capabilities, and caring practices. The National Micronutrient Strategy was finalized and costed. The standards for Micronutrient Powders (MNPs) were developed and approved by the Malawi Bureau of Standards (MBS) and the Malawi Medicines and Poisons Board, thereby ensuring local quality assurance.

UNICEF supported DNHA in conducting annual Scaling Up Nutrition (SUN) joint-assessment exercise (Figure 7) during 2018 and developed a report which was published in SUN website7. The report highlights the progress, gaps, emerging issues and priorities for the SUN implementation in the country. The progress marker assessed during the exercise were coordination, coherent policy and legal frameworks, aligning actions around common results framework and financial tracking and resource mobilization. UNICEF also supported DNHA in conducting an international food and nutrition research conference which provided a learning platform for evidence-based program design and implementation.

Figure 7: Annual SUN joint Assessment Exercise 2018

[7] https://scalingupnutrition.org/wp-content/uploads/2018/12/Malawi_Country_Profile_2018.pdf

UNICEF will continue supporting the DNHA in generation of evidence-based legislations, policy and strategies to address emerging issues such as adolescent undernutrition, nutrition sensitive agriculture, for improved nutrition governance. UNICEF will continue to advocate for improved domestic resource allocation for nutrition programming. UNICEF will support DHNA to develop more stringent systems to enforce the policies and strategies and will continue to advocate with district councils for specific budget line for nutrition interventions.

UNICEF collaborated with other UN agencies in hosting two high level nutrition advocates namely the Global Coordinator for Scaling Up Nutrition (SUN) and FAO Ambassador for Nutrition. UNICEF also supported high level advocacy meetings with Government, parliamentarians, donors and civil society organization where a political commitment was made to raise the profile of nutrition in the country and increase national investment and budget allocations for nutrition across different.

3.2 Output 2: The nutrition surveillance system composed of nutrition databases, real-time-monitoring and coverage surveys desegregated by sex is effectively integrated* into DHIS II by 2018

All 29 districts were able to monitor, and track nutrition indicators disaggregated by sex using DHIS2. A quarterly dashboard (Figure 8) was developed based on key performance indicators for CMAM for the period of Jul-Sep 2018 in DHIS2 which improved access to and utilization of data at national and district levels. A total of 157 district officials (126M; 31F) from 29 districts were better able to use the revised monitoring tools. This has resulted in improved quality of data and increased reporting rate for CMAM from 99 percent in 2017 to 100 percent in 2018. UNICEF provided technical assistance to DNHA to plan, monitor and evaluate through capacity building of national and district officials in using NNIS. The capacity of 118 district officials was enhanced to use NNIS, which increased the reporting rate from 21 percent (6/28 districts) in 2017 to 64 percent (18/28 districts) in 2018. In addition to that, fortification, resource tracking and care group modules were developed in the NNIS for effective monitoring at district and community levels. With the integration of care group module in the NNIS, four district councils were able to monitor and track community nutrition indicators ensuring timely feedback and corrective actions in targeted communities. As a part of integration process, nutrition indicators from information systems RONDAMS, Fortify MIS and School Health and Nutrition Information System were included in NNIS. Inter-operability between the DHIS2 and the NNIS enabled districts to monitor and track indicators across the sectors (Health, Agriculture, Education, Gender, Social Protection and WASH).
Please refer to Figure 9 for District Multi-Sector Nutrition Dashboard.

UNICEF supported the situation analysis on the performance of key nutrition indicators, which was used to develop a tracking dashboard and enabled districts to identify and prioritize nutrition actions. As a result, 28 evidence-based quarterly district action plans were developed by district nutritionists. Further, periodic data analysis, reports, advocacy materials and feedback to Government at national and district level were provided by UNICEF to support evidence generation. Six development partners were able to track, monitor and report on budget and expenditure and identify financial gaps for nutrition programming. This reduced duplication and maximized efficiencies in the utilization of nutrition resources. As an innovation, a real-time SMS-based stock

monitoring system was developed and rolled-out, which improved district capacity to monitor Ready-to -Use Therapeutic Food (RUTF) in 29 districts. The facility-reporting rate for RUTF stock increased from 37 percent in 2017 to 61 percent in 2018.

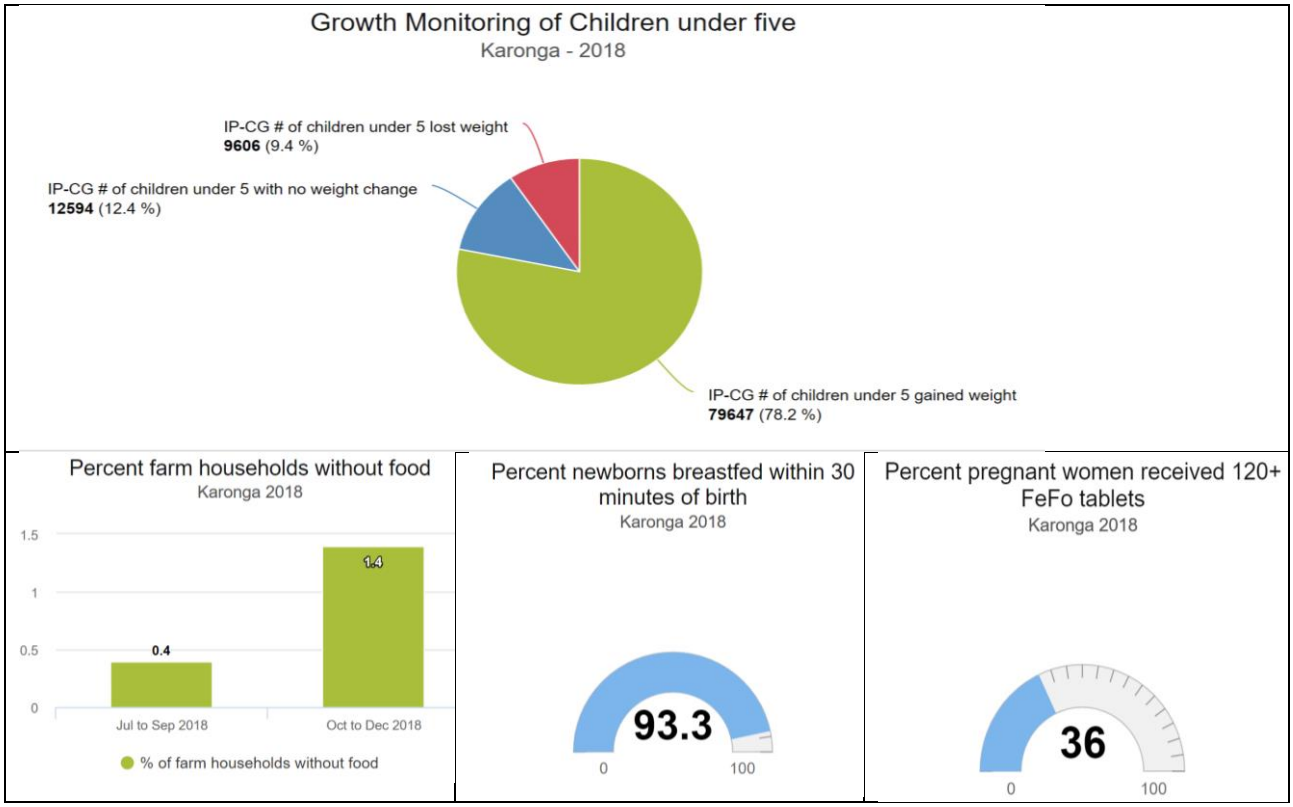

Figure 8 District Multi-Sector Nutrition Dashboard in NNIS - Karonga

All ten targeted District Monitoring and Evaluation Committees improved knowledge and skills in planning, implementation, monitoring, evaluation of nutrition specific and nutrition sensitive interventions. As a result, all ten district assemblies produced costed quarterly and annual work plans, which will guide implementation of Nutrition Sensitive Agriculture (NSA) activities. Additionally, UNICEF collaborated with DNHA and academia in conducting the SMART Survey in 2018, which provided data to inform evidence-based humanitarian response plan and support resource mobilization.

3.3 Output 3: Institutions (national – MoH and selected district) are able to plan, manage, and monitor for improved quality CMAM, micronutrient and IYCF service delivery incorporating bottleneck analysis by 2018

Children with SAM had increased access to community management of acute malnutrition (CMAM) services, evidenced by increase in CMAM sites from 722 in 2017 to 724 by 2018 against the 731 targeted sites, representing 99 per cent geographic coverage. A total of 2,763,388 (1,298,792 male and 1,464,596 female) children under five were screened for acute malnutrition through active case finding, which contributed to 45,085 children being admitted for SAM treatment. UNICEF advocated for, and provided, technical and financial support to strengthen the national supply chain

management system and ensured integration of nutrition supplies, as a part of system strengthening for effective monitoring within Government structures. As a result, therapeutic nutrition supplies are integrated with the Essential Medical List in the national supply chain management system.

The districts were better able to monitor nutrition supplies, as they are integrated with the Ministry of Health Logistics Management Information Systems (LMIS). UNICEF supported the timely provision, availability, and appropriate utilization of life-saving nutrition supplies, including Ready-to-Use Therapeutic Food, F75, F100, ReSoMal and other essential drugs (namely; amoxicillin, vitamin A, folic acid and Albendazole) in all the 724 health facilities. A total of 1,237 (594 male, 643 female) health workers, including nutritionists and pharmacy focal persons, in all health facilities in Malawi improved knowledge and skills to use LMIS, which resulted in effective and efficient management of stocks at health facilities by the pharmacy department.

UNICEF provided technical assistance to MoH towards mentorship, supervision, stock management, active case finding, monitoring and reporting of the CMAM programme at district- and health facility-level through the deployment of nine Nutrition Field Monitors. With these collective actions from UNICEF in collaboration with MoH, the performance of health facilities to provide quality CMAM services has significantly improved, evidenced by maintaining the key indicators within the Sphere standards (cure rate 93.7 percent against more than 75 percent), death rate 2.2 percent (below 10 percent), and defaulter rate 2.5 percent (below 15 percent). In addition to that, UNICEF coordinated 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.

A total of 810,388 community members (551,042 female, 259,346 male) including 1,073 local leaders (Figure 10) in five districts increased their knowledge and skills in optimal MIYCF practices through behavior change and communication interventions. In addition, 156 traditional healers increased their knowledge in the causes and management of acute malnutrition and are encouraging their communities to adopt health seeking behaviors and positive nutrition practices. All targeted districts were able to implement quality complementary feeding (CF) using point of use micronutrient powders (MNPs) and a total of 287,480 children (140,865 male, 146,615 female) received MNPs. UNICEF collaborated with WFP to support the Government to scale-up complementary feeding using point-of-use fortification in 14 districts. To address the challenge of insufficient staff trained in IYCF, 3,775 frontline workers (1,852M, 1,923F) had their knowledge improved on CF using MNPs, representing 94 per cent of the target.

Figure 9 A Female Group Village Headman taking notes on the Care Group Model in Chikwawa

A total of 5,916 service providers (2,500 Health Surveillance Assistants; 3,400 School Health and Nutrition teachers; 16 DNCC members) from the six targeted pilot districts gained knowledge and skills to implement adolescent iron and folic acid (IFA) supplementation using school and community-platforms. In addition, 19 out of the targeted 30 national government nutrition and health officers (14 female, 5 male) from different ministries improved their knowledge and skills in effective adolescent IFA supplementation programme. UNICEF supported DNHA to develop nutrition education materials, monitoring and reporting tools and procured of IFA supplements to prevent anaemia among adolescent and pregnant mothers in six pilot districts with IFA supplementation.

UNICEF extended its partnership to District Councils, World Relief International, World Vision Malawi, the Story Workshop, ADECOTS and Catholic Relief Services UBALE project and Project Concern International, for ensuring quality CMAM, micronutrient and IYCF services to women and children.

3.4 Output 4: Capacities of implementing partners in 15 selected districts enhanced to promote appropriate household behaviours and social change for maternal nutrition, infant and young child feeding and care practices* to increase resilience in the community

A total of 220,897 caregivers of children under two years received counselling on key child feeding and caring practices and 6,340/6,000 (106 percent) frontline workers (FLWs) in 15 target districts improved their knowledge and skills in optimal breastfeeding and complementary feeding; food fortification; integrated homestead farming; WASH; health; and monitoring and reporting. In

addition, this led to improved district and community level multi-sectoral governance for nutrition. A total of 9,818 care group promoters (5,891 male, 3,927 female) and 25,039 care group cluster leaders (CL) (2,696 male, 22,343 female) had their knowledge and skills improved in the delivery of MIYCN and nutrition-sensitive interventions.

A total of 36,182/50,000 (72 percent) households established backyard gardens and 73,362/80,000 (92 percent) acquired small livestock, thereby increasing access to diversified diets for under-five children and women. In addition, 287,480 children (140,865 male, 146,615 female) accessed quality and improved complementary foods using point of use fortification through MNPs. These findings are validated in the subnational 2018 LQAS, MAD improved from 10.5 percent in 2017 to 14.4 per cent in 2018. Availability of water remained a key challenge for the establishment of backyard gardens, hence UNICEF Malawi advocated adoption of low cost water saving technologies.

A total of 118,402/166,128 (71 percent) households had a hand washing facility with soap and 154,808/166,128 (93 percent) households had a pit latrine. There was significant improvement in WASH indicators with a 25 percent increase in hand washing facilities and a 54 percent increase in constructed pit latrines compared to 2017.

Capacities of 230 District Nutrition Coordination Committee (DNCC) members (154 male, 76 female) were strengthened to plan, monitor and implement Nutrition Sensitive Agriculture (NSA) and MIYCN interventions. The DNCCs supported the strengthening of 107 Area Nutrition Coordination Committee (ANCCs) comprised of 668M and 182F and 297 Village Nutrition Coordination Committee (VNCCs) comprised of 1,069 males and 476 female members. A total of 158,000 households were mobilized for behavior change and adoption of NSA and MIYCN practices. UNICEF supported the strengthening of nutrition governance structures at district- and community-level including repositioning of DAES in its strategic role to tackle food and nutrition security issues and the reactivation of the NSA national technical working group (TWG), which is responsible for providing strategic and policy guidance on NSA. In addition to that, UNICEF in collaboration with FAO supported the standardization of a training package on Integrated Homestead Farming (IHF) and the Nutrition Sensitive Agriculture (NSA), which will be used to build the capacity of national, district and community-level officers to implement the NSA.

Figure 10 A theatre development session in progress in Chikwawa

A total of 426,414 caregivers had their skills and knowledge on MIYCN enhanced through interpersonal communication, Theatre for Development (Figure 11), community dialogues (CD), cultural festivals, cooking demonstrations, community meetings and social mobilization. In addition, 61 CD, 1,960 members of ANCC, Area Development Committees (ADC), Area Community Leaders Action Group on Nutrition (ACLANs), Community Leaders Action Group on Nutrition (CLANs) were able to develop and implement community action plans to reduce stunting. Further, six community radio stations aired 32 programmes promoting complimentary feeding using MNPs, reaching 6,500 caregivers. In addition, ten radio programmes, reaching 8.8 million people with messages on optimal MIYCN, Water, Sanitation and Hygiene (WASH) and health seeking behaviors, were broadcasted on national radio.

4 FINANCIAL ANALYSIS

Table 1: 2018 Planned budget by Thematic Sector (Nutrition)

Intermediate Results	Funding Type[1]	Planned Budget[2]
2.2.1 The nutrition sector (DNHA) capacity to coordinate evidence-based legislations and costed strategic plans	RR	294,000.00
	ORR	446,000.00
2.2.2 National Nutrition Information System	RR	266,000.00
	ORR	1,944,940.00
2.2.3 Improved quality of CMAM, micronutrient and IYCF service delivery including nutrition emergencies	RR	350,000.00
	ORR	8,458,971.94
2.2.4 Household behaviors and social change for maternal nutrition, IYCF and care practices	RR	80,000.00
	ORR	6,262,960.00
Total Budget		**18,102,872**

Table 2: Country-level Thematic contributions to outcome area received in 2018

Donors	Grant Number*	Contribution Amount	Programmable Amount
Swiss Committee for UNICEF	SC1899030015	45,408.68	45,408.68
Total		**45,408.68**	**45,408.68**

Table 3: Expenditures in the Thematic Sector

Organizational Targets	Expenditure Amount*			
	Other Resources - Emergency	Other Resources - Regular	Regular Resources	All Programme Accounts
21-04 Prevention of stunting and other forms of malnutrition	(31,751.46)	7,881,744.84	1,048,865.97	8,898,859.35
21-05 Treatment of severe acute malnutrition	1,011,286.15	3,312,613.43	273,245.49	4,597,145.06
21-09 Adolescent health and Nutrition (10 to 19 years)	(1,244.83)	207,195.47	4,851.91	210,802.55
Total	**978,289.86**	**11,401,553.73**	**1,326,963.37**	**13,706,806.97**

Table 4: 2018 Expenditures by Key-Results Areas (in US Dollars)

Organizational Targets	Expenditure Amount*			
	Other Resources - Emergency	Other Resources - Regular	Regular Resources	All Programme Accounts
21-04 Prevention of stunting and other forms of malnutrition	7,840.24	5,478.70	-	13,318.94
21-05 Treatment of severe acute malnutrition	11,437.38	155.45	-	11,592.84
21-09 Adolescent health and Nutrition (10 to 19 years)	-	11,465.22	-	11,465.22
Total	**19,277.63**	**17,099.37**	**-**	**36,376.99**

Table 5: Expenses by Specific Intervention Codes

Organizational Targets	Expenditure Amount*
21-04-01 Breastfeeding protection, promotion and support (including work on Code)	164,099.61
21-04-02 Diet diversity in early childhood (children under 5), includes complementary feeding and MNPs	3,727,347.61
21-04-03 Vitamin A supplementation in early childhood (children under 5)	2,124,287.33
21-04-05 Maternal nutrition, including information, supplementation and counselling	923,710.57
21-04-06 Salt iodization and other large-scale food fortification	(374.93)
21-04-07 National multisectoral strategies and plans to prevent stunting (excludes intervention-specific strategies)	48,630.42
21-04-08 Data, research, evaluation, evidence generation, synthesis, and use for prevention of stunting and other forms of malnutrition	23,180.60
21-04-99 Technical assistance - Prevention of stunting and other forms of malnutrition	1,358,421.48
21-05-01 Care for children with severe acute malnutrition	3,174,315.66
21-05-02 Capacity building for nutrition preparedness and response	(18,160.88)
21-05-03 Nutrition humanitarian cluster/humanitarian sector coordination	1,483,102.30
21-09-02 Prevention of undernutrition in adolescence (10 to 19 years)	213,566.74
Grand Total	**13,222,126.51**

Table 6: Planned Budget and Available Resources for 2019

Intermediate Result	Funding Type	Planned Budget	Funded Budget	Shortfall
Output 1.1 Parents and caregivers, with a focus on adolescent mothers, have the capacity to engage in responsive and positive parenting practices (ECD)	RR	180,000	180,000	0
	ORR	1,745,000	625,000	1,120,000
Output 1.2 Health and nutrition service delivery points in targeted districts have the capacity to deliver good quality MNCH, HIV and nutrition services for all children (0-5 years) and are enabled to promote healthy behaviors	RR	770,000	770,000	0
	ORR	15,038,085	10,249,312	4,788,773
Output 1.3 Community Based Child Care Centers (CBCC) that meet national ECD standards are increased	RR	50,000	50,000	0
	ORR	650,000.00	0	650,000
Sub-total Regular Resources		**1,000,000**	**1,000,000**	**0**
Sub-total Other Resources - Regular		**17,433,085**	**10,874,312**	**6,558,773**
Total for 2019		**18,433,085**	**11,874,312**	**6,558,773**

5 FUTURE WORK PLANS

UNICEF will continue supporting the DNHA in generation of evidence-based legislations, policy and strategies to address emerging issues such as adolescent undernutrition, nutrition sensitive agriculture, for improved nutrition governance. UNICEF will continue to advocate for improved domestic resource allocation for nutrition programming. UNICEF will support DHNA to develop more stringent systems to enforce the new/revised policies and strategies. UNICEF will continue to advocate with district councils for specific budget line for nutrition.

The National Multi-Sector Nutrition Information System will continue to be integrated in other existing systems in all relevant sectors (agriculture, health, food, WASH, Social Protection, education and ECD). UNICEF will invest in improved tracking of nutrition indicators from the community-level to enable timely responses and corrective actions. Additionally, UNICEF will increase efforts to use innovative technology such as, drones, for more timely planning and reporting.

UNICEF will continue strengthening the national health systems at all levels including supply chain integration to ensure effective implementation and sustainability of quality nutrition-specific interventions in the country. UNICEF will also continue lobbying Government to incorporate costs of nutrition interventions, including procurement of supplies, into the national budget and to

decentralize CMAM care through integrated community case management (iCCM) at village clinics. This will serve to address some of the challenges related to capacity of health workers and the management of severe acute malnutrition.

Based on the lessons learnt and evidence generated in the current Country Programme and using the life cycle approach with special focus on adolescents, UNICEF will continue with strategies that have been proven to work whilst harnessing new innovations to spearhead implementation of integrated nutrition-sensitive and specific interventions. The scaling-up nutrition and nutrition-sensitive agriculture programmes are multi-year programmes and will continue in the 2019-2023 Country Programme.

6 EXPRESION OF GRATITUDE

UNICEF Malawi Country Office is grateful for the Global Nutrition Thematic fund support to the most vulnerable children in Malawi contributing to reduced morbidity and mortality due to undernutrition. The flexibility of the thematic support contributed to UNICEF achieving the results against the target which demonstrate the need to continue with multi sectoral coordination for improved nutrition outcomes. Secondly, UNICEF Malawi express its gratitude to Department of Nutrition in leading the coordination, advocacy, policy oversight for the multi-sector nutrition response in the Country. UNICEF Malawi also appreciate the support of the European Union (EU), World Bank (WB), Food and Agriculture Organization of the United Nations (FAO), Germany/ GIZ, Germany/ KFW, WFP, Irish Aid, Government of Canada, USAID, Government of Japan, BMZ, DFID, CIDA for their financial support and commitment towards improving the nutrition status of women and children in Malawi.

Annex 1 - Results Framework for 2018

Indicators	Baseline 2017	Target 2018	Progress 2018	Assessment	Means of Verification
Proportion of boys and girls aged 0–5 months exclusively breastfed in selected district	61%	61%	61% (87% LQAS subnational survey 2018)	Some progress	MICS/DHS
Proportion of boys and girls 6-23 months who receive a minimum acceptable diet in selected districts	8%	8%	8% (14% LQAS subnational survey 2018)	On track	MICS/DHS
Percentage of boys and girls 6-59 months with SAM who are admitted and recover (through UNICEF supported programming)	94%	95%	94%	On track	MNMS/MICS/DHS
Percentage of girls and boys 6-59 months that received two annual doses of vitamin A supplementation.	100%	100%	88%	Some progress	Sector MIS
Proportion of boys and girls 12 months to 59 months who received two doses of deworming medication disaggregated by age and sex	100%	100%	95%	On track	Sector MIS
Proportion of targeted SAM boys and girls aged 6 to 59 months admitted for treatment in CMAM program	70%	75%	89%	On track	Sector MIS-tentative report
Proportion of households consuming iodized salt by 2018	90%	90%	90%	On track	Sector MIS-tentative report
Existence of a costed national strategy and implementation plan targeting anaemia reduction in women and girls	0	1	1	On track	National Nutrition Committee Meeting Minutes
Formalization of Food Standards (MNPs, RUTF, Complementary foods)	0	1	1	Some progress	National Nutrition Committee Meeting Minutes
Costed Micronutrient Strategy developed	0	1	1	On track	National Nutrition Committee Meeting Minutes
Scaling Up Nutrition - Nutrition Education Communication Strategy (SUN-NECS) II developed	0	1	1	On track	National Nutrition Committee Meeting Minutes
Maternal, Infant and Young Child Nutrition Strategy (MIYCN) developed	0	1	0	Some progress	National Nutrition Committee Meeting Minutes

Existence of a national management information system that includes disaggregated data on nutrition by 2018	No community surveillance system	Community surveillance system available	The DNHA has harmonised the care group reporting tools, but not oriented the implementing partners at national and district level. The UN joint programme Afikepo will be great opportunity to roll-out the harmonised care group tools in 10 districts in 2019.	Some progress (Dowa, Karonga, Chitipa and Salima districts are using community surveillance system	National Multi-Sector Nutrition Information System
Number of Sphere standards met (in relation to the management of SAM)	3	3	3	On track	National CMAM database-DHIS II
Percentage of districts providing care for children with SAM as part of regular health and nutrition services	100%	100%	100%	On track	National CMAM database-DHIS II
Number of girls and boys with severe acute malnutrition (SAM) who are admitted for treatment	47,447	50,644	45,085	On track	National CMAM database-DHIS II
Proportion (number) of facility-based health workers in 15 districts trained on IYCF	0%	30%	94% (3,775 frontline workers (1,852 male, 1,923 female))	On track	DNHA reports
Number of districts providing Micronutrient powders to children 6-23 months	2	12	14	On track	DNHA reports
Number of girls and boys who received multiple micronutrient powders through UNICEF-supported programmes	42,067	392,280	220,294 children (107,944 male, 112,350 female)	Some progress	National Database
Number of adolescent girls provided with services to prevent anaemia and other forms of malnutrition through UNICEF-supported programs	0	120,000	122,185	On track	MOH administrative reports
Number of Community Health Workers (male; female) trained with UNICEF support to provide infant and young child feeding counselling services in the reporting year	1,800	6,000	6,340	On track	DNHA reports
Proportion of caregivers (male; females) of children under two received counselling on key child	15%	50%	81%	On track	DNHA reports

caring practices in 15 districts (EBF, CF, HIV, sanitation, hygiene and health)					
Percentage of districts implementing the minimum package to prevent stunting in children	13%	63%	93%	On track	DNHA reports

Annex 2 - Case Study: Evidence Generation for Action for CMAM

Top Level Results: Improved access to and use of CMAM data for planning and decision making in all the districts using DHIS2. The reporting rate for districts by 10th of every month, improved from 80 percent in 2016 to 99 percent in 2017 and 100 percent of facilities in 2018.

Background: The Ministry of Health is implementing DHIS-2 (District Health Information System version 2) aimed at supporting an integrated Health Information System (HIS) at district and national levels by improving data capture and analysis for programmes, data flows at facility, district and national levels and establishing a national data repository for indicator data. The Central Monitoring and Evaluation Department (CMED) in Ministry of Health is leading the implementation of the System at national and district levels. UNICEF Nutrition Section supported the Ministry of Health to strengthen the routine health information system and integration of nutrition indicators in DHIS2 in initial four districts and rolled out to all the districts.

Progress and Results: All 29 districts were able to track and monitor CMAM indicators disaggregated by age and sex using DHIS2. A quarterly interactive dashboard (Table 1) was developed based on key performance indicators for CMAM for the period of Jul-Sep 2018 in DHIS2 which improved access to and utilization of data at national and district levels. A total of 157 district officials (126M; 31F) from 29 districts were better able to use the revised monitoring tools for CMAM. This resulted in improved quality of data and increased reporting rate for CMAM from 99 percent in 2017 to 100 percent in 2018. To improve data quality, all facility reports were validated by district nutritionists and HMIS officers before uploading data in the DHIS2 as shown in Figure 8: CMAM Monitoring System – Information Flow. In addition to that, periodic data quality audits were conducted by Ministry of Health. Through regional review meetings, CMAM data were reviewed with all the districts, thereby ensured feedback mechanisms in place and utilized well. UNICEF consistently developed and shared CMAM updates through monthly nutrition bulletins; cluster meetings, DONUTS meetings and other humanitarian coordination platforms in the country. This was recognized as a best practice by all stakeholders. These bulletins were disseminated through email sharing as well nutrition cluster web page.

Criticality and value addition: The routine CMAM data in DHIS2 is being used for nutrition emergency preparedness and response. The system helps nutrition stakeholders in providing trends in CMAM admission rates, key performance indicators which were used for planning, advocacy and resource mobilisation. Further, caseloads at health facilities were used for timely procurement and

distribution of life-saving therapeutic supplies (RUTF, F-75, F-100) and essential drugs for treatment of children with severe acute malnutrition. Based on the number of deaths at NRUs reported, death audits were conducted by Ministry of Health.

Challenges and Lesson Learned: There are still challenges in terms of data collection from health facilities, sometimes delayed reporting affects timeliness for CMAM data. The DHIS2 has WHO data quality tool to check correctness, consistency and timeliness but not used for CMAM. In addition to that, validation rules, outlier analysis are available to improve data quality but not used.

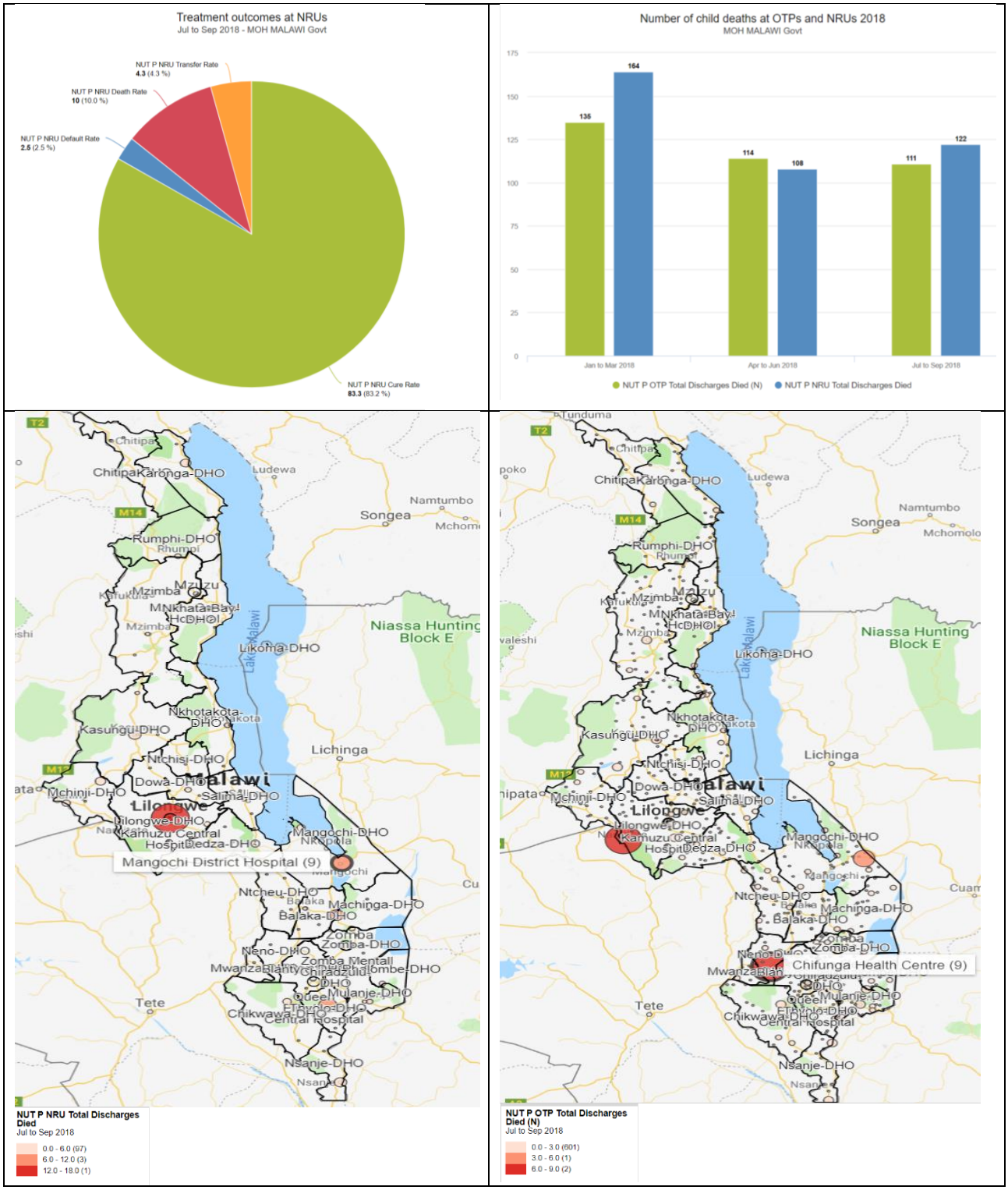

Figure 11 Interactive Quarterly CMAM Dashboard in DHIS2

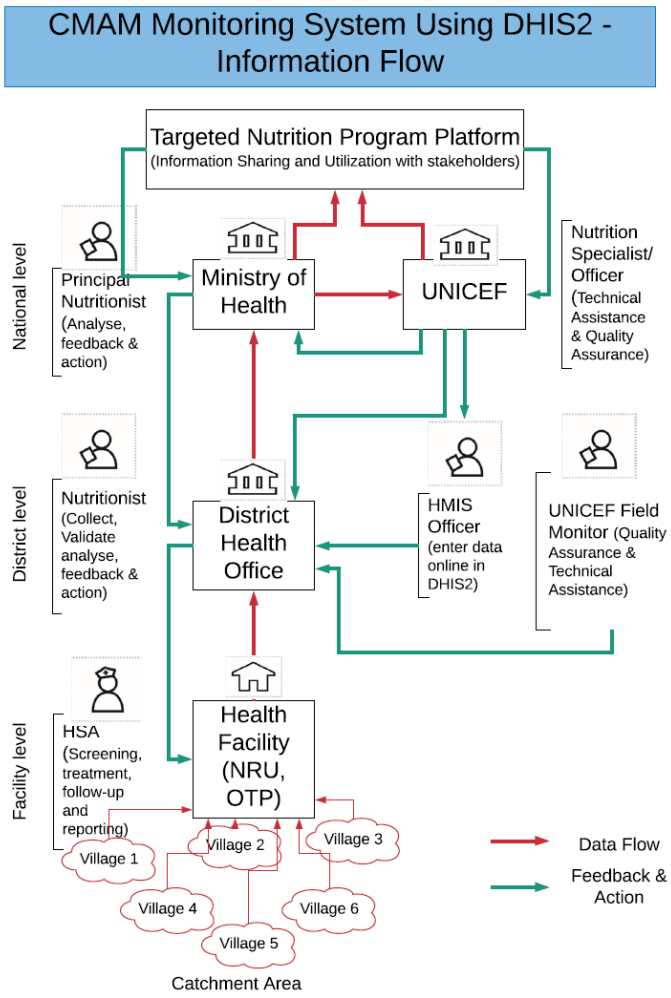

Figure 12 CMAM Monitoring System – Information Flow

Moving Forward: UNICEF will continue focus on systems strengthening, capacity building, advocacy for use data for actions using DHIS2. Specifically, UNICEF will support revision of DHIS-2 indicators to include other nutrition indicators and will continue to provide technical support to nutrition data unit at MoH. UNICEF will also ensure systematic data quality, data analysis methodologies in place and used for evidence-based decision making at all levels. Additionally, UNICEF will support and invest in strengthening the community-based monitoring systems and linking with facility-based DHIS2.

Annex 3 - 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 in regard to 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 with regard to 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!