Zambia

Consolidated Emergency Report 2021

(a) Left: A health worker conducting Infant Young Child Feeding (IYCF) counselling session with a beneficiary at a health facility in Lusaka district, using IYCF counselling booklet; printed with support from UNICEF and other donors.
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(b) Right: Trained community volunteers taking anthropometric measurements of a beneficiary at an outreach site, in Western province.
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B. EXPRESSION OF THANKS

UNICEF's work is funded entirely through individual donations and the voluntary support of our partners in government, civil society and the private sector. Voluntary contributions enable UNICEF to deliver on its mandate to protect children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential.

The thematic funding contributed to ensuring delivery of essential multisectoral nutrition specific, nutrition sensitive interventions and life-saving nutrition services for children and women in 58 drought-affected districts in the 17 Scaling-Up Nutrition Phase II programme (SUN II) districts, and in the seven districts of Luapula province, including collaboration and leveraging resources from other stakeholders. This has allowed the programme to be more responsive to expressed needs and improved effectiveness resulting in accelerated implementation of treatment and prevention services.

We take this opportunity to thank all our partners for their commitment and trust in UNICEF.

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D. ACRONYMS

CERF	Central Emergency Response Fund
COAR	Country Office Annual Report
CRS	Catholic Relief Services
DHIS2	District Health Information System 2
DMMU	Disaster Management and Mitigation Unit
ECHO	European Commission Humanitarian Aid
FCDO	Foreign, Commonwealth and Development Office
GDP	Gross Domestic Product
KfW	German Development Bank
GHTF	Global Humanitarian Thematic Funding
GMP	Growth Monitoring and Promotion
GRZ	Government of the Republic of Zambia
HMIS	Health Management Information System
IMAM	Integrated Management of Acute Malnutrition
IPC	Infection Prevention and Control
IPC	Integrated Phase Classification
ITP	Inpatient Therapeutic Programme
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child Feeding in Emergencies
MAM	Moderate Acute Malnutrition
MAIYCN	Maternal, Infant and Young Child Nutrition
MoH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
NFNC	National Food and Nutrition Commission
NGOs	Non-Governmental Organisations
OTP	Outpatient Therapeutic Programme
PLAN	Plan International
PPE	Personal Protective Equipment
SAM	Severe Acute Malnutrition
SUN	Scaling-Up Nutrition
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund

VAC	Vulnerability Assessment Committee
WHO	World Health Organization
ZDHS	Zambia Demographic and Health Survey

E. EXECUTIVE SUMMARY

Zambia is a lower-middle-income country with a population of 18.4 million people.[1] Zambia is prone to drought and the most recent drought was in 2018 and 2019 where 58 out of 116 districts were severely impacted. This resulted in 19 per cent of the rural population in Zambia requiring assistance to protect their livelihoods and reduce food consumption gaps. The 2019 Vulnerability Assessment Committee (VAC) revealed an increase in the rate of acute malnutrition levels in Zambia. Acute malnutrition (wasting) rose to nearly 6 per cent across the nine provinces of Zambia. The high prevalence of food insecurity resulted in an increase in acute malnutrition cases, sub-optimal Infant and Young Child Feeding (IYCF) practices and other forms of malnutrition in food insecure districts.

According to the Zambia Demographic and Health Survey 2018 (ZDHS 2018), 35 per cent of children under age five were stunted, 4 per cent were wasted,12 per cent were underweight, 5 per cent were overweight, and 70 per cent children aged 0–5 months were exclusively breastfed. Malnutrition is responsible, directly or indirectly, for 45 per cent of deaths among children under age five in the world. Severe Acute Malnutrition (SAM) or severe wasting is a life-threatening condition requiring urgent treatment. Wasting in early childhood can lead to dire consequences, increasing mortality by 9–12 folds for children with SAM, four folds for children with Moderate Acute Malnutrition (MAM), and increasing the likelihood of contracting infectious diseases.[2] Children with wasting are also more likely to become stunted with long-term consequences of overweight, susceptible to non-communicable diseases, and impaired cognitive development later in life.

SAM or severe wasting is the most immediate, visible, and life-threatening form of malnutrition. Wasting and other forms of acute malnutrition are the result of maternal malnutrition, low birthweight, poor feeding and care practices, and infection. SAM is exacerbated by food insecurity, limited access to safe drinking water and poverty. Poor consumption of nutrient rich foods by households increases the risk of irreversible chronic nutrient deficiencies.

Good nutrition at an early age lays the foundation for lifelong health, learning and economic and social performance. It is important to prevent all forms of malnutrition by adopting prevention strategies, early detection, and treatment of SAM.

In Zambia, the combination of recurrent drought, floods, and COVID-19 has compromised the nutrition situation and exacerbated the existing poor nutritional status of children and maternal nutrition. Zambia adopted the Integrated Management of Acute Malnutrition (IMAM) as an approach to treat acute malnutrition, thus ensuring a continuum of care including both SAM and

[1] https://www.giz.de/en/worldwide/338.html.

[2] Olofin I, McDonald CM, Ezzati M, Flaxman S, Black RE, Fawzi WW, et al. *Associations of suboptimal growth with all-cause and cause-specific mortality in children under 5 years: a pooled analysis of 10 prospective studies*. PLoS ONE. 2013; 8(5): e64636 10.1371/journal.pone.0064636.

MAM. UNICEF Zambia has supported the Ministry of Health (MoH) to implement a life-saving programme on the IMAM together with IYCF interventions.

Despite the challenges encountered in 2021 including the COVID-19 situation, notable progress was recorded in the nutrition sector and summarised as follows:

1. A total of 41,150 acutely malnourished [9,955 (SAM) and 31,195 (MAM)] children were identified and admitted in the Outpatient Therapeutic programme (OTP) in the 58 drought-affected districts and in Luapula province. The programme achieved 79 per cent cure rate, 1 per cent mortality rate and 20 per cent defaulter rate for children with SAM; 84 per cent cure rate, 0 per cent mortality and 16 per cent defaulter rate was observed for children with MAM. Children with MAM were admitted and treated in OTPs through the expanded criteria using Ready-to-Use Therapeutic Food (RUTF).
2. A total of 4,894,362 children received Vitamin A supplementation while breastfeeding and complementary feeding messages reached 258,688 women and caretakers.
3. An estimated 206,569 children received Growth Monitoring and Promotion (GMP) services.
4. UNICEF through its partners, supported and strengthened life-saving interventions through the IMAM programme and as a result of these efforts, a monthly average of 228,227 children aged 6–59 months were screened.
5. UNICEF supported the National Food and Nutrition Commission (NFNC) to strengthen coordination structures involving multiple ministries and helped ministries to deliver essential multisectoral nutrition services.
6. Through technical and financial assistance, UNICEF supported the MoH in building and strengthening capacities of service providers to deliver quality nutrition therapeutic services. This resulted in a total of 1,573 health workers, 6,802 volunteers and 100 Non-Governmental Organisation (NGO) staff being trained in IMAM and Infant and Young Child Feeding in Emergencies (IYCF-E) in the 58 drought-affected districts and 130 health workers and 516 volunteers in the seven districts of Luapula province. This effort resulted in increased IMAM coverage.
7. Through technical and financial support, UNICEF facilitated the alignment of the IMAM and IYCF-E training package to the recent global updates. The support also included the printing of materials that facilitated the roll out of capacity building activities.
8. Revision of monitoring tools in line with recent global updates was achieved including printing and distribution to ensure capacity building, increased reporting and improved data quality.
9. UNICEF in collaboration with the MoH conducted an orientation of MoH staff in data audit leading to improvement in reporting and data quality in the 58 districts.
10. To support service delivery, UNICEF procured additional 2,800 cartons of RUTF and facilitated distribution of supplies and equipment. Through UNICEF support, 7,304 aprons and 7,304 gumboots were also procured as motivational supplies to augment the activities of volunteers at the community level.
11. Procurement and distribution of COVID-19 mitigation supplies [Personal Protective Equipment (PPEs)] and remote monitoring helped ensure overall consistency and continuity of service delivery in the 58 drought-affected districts. To strengthen and

support evidence generation, a Standardized Expanded Nutrition Survey (SENS) was conducted in three refugee camps: Mantapala (Nchelenge), Mayukwayukwa (Kaoma) and Maheba (Solwezi) with support from UNICEF and the United Nations High Commissioner for Refugees (UNHCR). The findings will continue to inform nutrition programming.

12. The family Mid-upper Arm Circumference (MUAC) approach was adopted in Lusaka district with a total of 241 health workers and 897 volunteers trained including 284,930 caretakers to identify early signs of malnutrition in their children using the MUAC tape.

The documented achievements have been attributed to the availability of funding, timely procurement and delivery of supplies, and equipment including effective coordination and partnerships with the various stakeholders. The overall emergency response in all the 58 drought-affected districts was financially supported by thematic funding through contributions from the Foreign, Commonwealth and Development Office (FCDO), the European Commission Humanitarian Aid (ECHO) and the Central Emergency Response Fund (CERF). The humanitarian thematic funding helped to complement the support to the IMAM programme, especially with the ending of the nutrition funding support from other donors.

During the period under review, UNICEF continued to support the districts and the Government of the Republic of Zambia (GRZ) in increasing scale up of IMAM services in line with the Sustainable Development Goals, and UNICEF's Strategic Plan 2018–21. Zambia has been affected by the COVID-19 pandemic, with the first case reported on 18 March 2020. As of 31 December 2021, Zambia reported 254,274 confirmed cases with 3,734 deaths and 219,794 recoveries.[3] COVID-19 continued to compromise programme implementation with the imposed restrictions causing disruption and suspension of outreach services and trainings and nutrition services at the facility and community level.

To ensure effective delivery of services, UNICEF worked closely with the government line ministries/agencies, and partners. The IMAM programme was implemented under the leadership of the MoH with technical support from UNICEF, and the three implementing partners namely World Vision International (WVI), PLAN International (PLAN) and People in Need. Under the Scaling-Up Nutrition (SUN-II) programme, the partnership of the five donors namely Sweden, Irish Aid, FCDO, German Development Bank (KfW) and the European Union, and the five implementing partners [Save the Children International, WVI, CARE International, Catholic Relief Services (CRS), and PLAN] ensured financial support and implementation for malnutrition prevention and treatment services.

Due to the COVID-19 pandemic, the prevention measures and restrictions affected the programme implementation of nutrition activities at district and community level. To mitigate the situation, UNICEF supported the MoH to procure PPEs for service providers. This offered protection to the service providers and ensured continued implementation of the life-saving nutrition key activities, which helped mitigate the negative impacts on the programme implementation.

[3] Zambia National Public Health Institute

To sustain the gains achieved in 2021 and further address the critical nutrition issues in Zambia, in 2022, UNICEF plans to continue supporting the GRZ both technically and financially with service delivery, procurement of programme supplies, strengthening capacities of service providers and monitoring of programme implementation.

UNICEF Zambia appreciates and underlines its gratitude for the generous contribution of thematic funds. The flexibility support made it possible to respond quickly to emerging challenges and vulnerabilities of children and their families in 2021.

F. HUMANITARIAN CONTEXT

(i) Country trends in the situation of children vis-a-vis the outcome area:

As earlier indicated, Zambia is a lower-middle-income country and its population currently stands at 18.4 million people.[4] Zambia has an increasing influx of populations to the urban areas with high registered urban population growth trends; approximately 59 per cent of the population resides in rural areas. The country is characterised by high levels of inequity in income distribution—with three quarters of its population estimated to be living on less than US$1.90 per day—high inequality regarding wealth distribution and high poverty levels.[5]

Malnutrition remains a key nutrition challenge in Zambia, manifesting itself in the form of stunting (chronic malnutrition) and wasting (acute malnutrition) and affects mostly children, adolescents, and women. Although there has been a decrease in stunting over the years from 40 per cent in 2014, the prevalence was 34.6 per cent in 2018 (ZDHS), with 4 per cent wasted,12 per cent underweight and 5 per cent overweight children in Zambia. The stunting levels still remain high in the country with inequity in stunting across the provinces and prevalence of stunting higher among children in rural areas (36 per cent) than among children in urban areas (32 per cent).[6] Wasting has reduced from 6 to 4 per cent in the same period though stagnating. Anaemia is high (58 per cent) among children aged 6–59 months and very high (>70 per cent) among children aged 6–23 months. Adolescent girls have higher anaemia (33 per cent) than women of reproductive age (31 per cent), with increasing rate of overnutrition among adolescent and women.

GRZ, through the Adolescent Health Strategy 2017–21, identified lack of relevant policies, laws and nutrition programmes targeting adolescents as barriers to optimal adolescent nutrition. Only 13 per cent of children aged 6–23 months were fed a minimum acceptable diet. Exclusive breastfeeding decreased by 3 per cent in last 5 years. With shrinking fiscal space to support essential interventions and disruption in health and food systems from drought, COVID-19 and inadequate government funding for IMAM programme, all forms of malnutrition including child stunting, micronutrient malnutrition, adolescent and maternal nutrition, including inequity, are expected to exacerbate in Zambia.

Inappropriate feeding practices of infant and young children remain a major cause of malnutrition in Zambia. Reduction in the number of meals and meal portions, inadequate access to food and issues of affordability all lead to poor infant feeding practices and a surge in cases of acute malnutrition.

Vulnerability in Zambia is characterised by a high incidence of poverty and exposure to several types of shocks mainly arising from hydro-meteorological hazards and their cascading effects, such as epidemics and periodic incidences of macroeconomic instability.[7] Zambia is prone to droughts. The combination of recurrent drought, floods and COVID-19 has exacerbated the existing poor nutritional status of children. The most recent drought occurred in 2018 and 2019

[4] https://www.giz.de/en/worldwide/338.html.

[5] UNICEF 2021 Situation Analysis of the Status and Well-Being of Children in Zambia.

[6] Ibid.

[7] IPC Acute Food Insecurity Analysis: July 2021–March 2022.

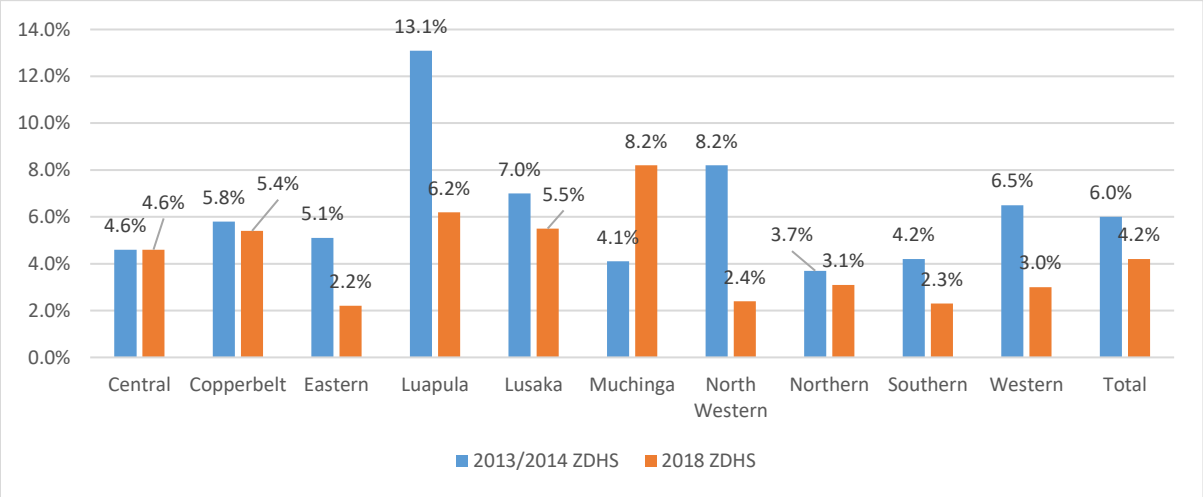
where 58 out of 116 districts were severely impacted. The 2019 VAC revealed an increase in the rate of acute malnutrition levels in Zambia, especially in food insecure districts. The onset of the drought, and later the COVD-19 pandemic in the first quarter of 2020 and its subsequent impacts in 2021 further compromised the nutrition situation. This affected IYCF practices and maternal nutrition practices with increased risk of sub-optimal complementary feeding, breastfeeding and maternal nutrition practices. This further exposed many children to an increased risk of morbidity and malnutrition, especially in infants and young children, which resulted in 19 per cent of the rural population in Zambia requiring assistance to protect their livelihoods and reduce food consumption gaps.

The vulnerability assessment conducted in July 2021 indicated that about 1.18 million people were facing crisis levels of food insecurity [as per the Integrated Phase Classification (IPC), Phase 3] and required urgent humanitarian action to reduce food gaps, protect and restore livelihoods, and prevent acute malnutrition. The country experienced shocks, which included flooding due to excessive rains leading to waterlogging of crops, outbreaks of African Migratory Locusts and Fall Armyworm affecting crops and resulting in reduction of food production and high maize prices.

A bottleneck analysis conducted in 2019 also identified that availability, accessibility, and quality of SAM treatment services remain poor nationwide and only 6 per cent of health workers have been trained on IMAM, with only 24 per cent of health facilities providing SAM management.

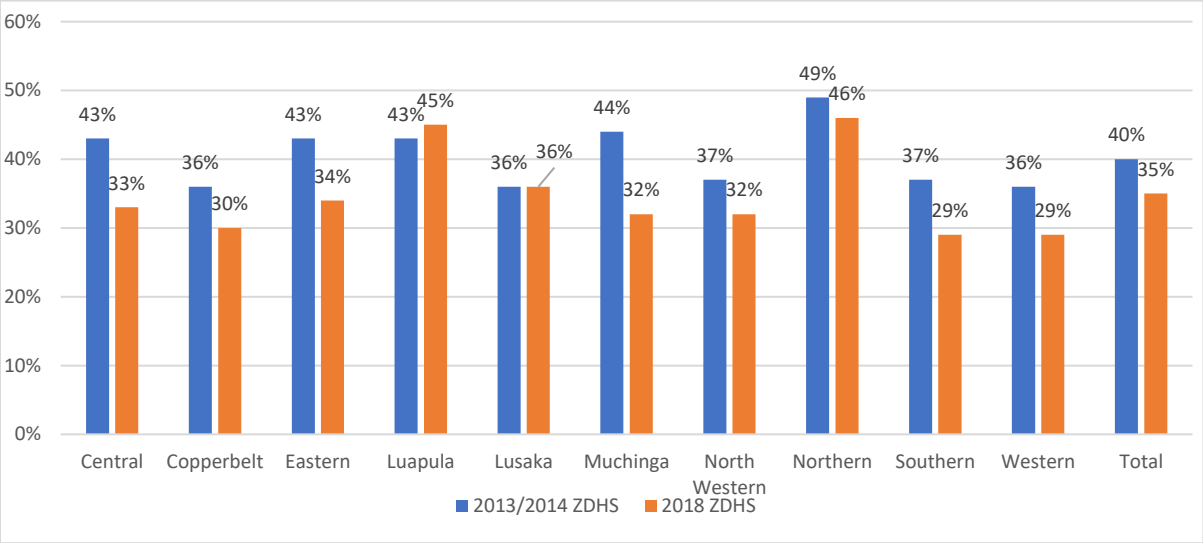
As mentioned earlier, SAM or severe wasting, is the most immediate, visible, and life-threatening form of malnutrition. Children with wasting are too thin and their immune systems are compromised, leaving them vulnerable to developmental delays, disease, and death. Good nutrition at an early age lays the foundation for lifelong health, learning and economic and social performance. It is important to prevent all forms of malnutrition by adopting prevention strategies, early detection, and treatment of SAM. See Figures 1 and 2 below on prevalence of wasting and stunting by province in Zambia over time.

Figure 1: Prevalence of wasting by province in Zambia



Source: ZDHS, 2018

Figure 2: Prevalence of stunting by province in Zambia



Source: ZDHS, 2018

The United Nations Global Action Plan on Child Wasting puts new emphasis on prevention of wasting through the scale-up of multisectoral interventions.[8]The MoH, UNICEF and partners have invested in implementing life-saving nutrition interventions through the IMAM programme together with IYCF interventions. Zambia adopted IMAM as an approach to treat acute malnutrition, ensuring a continuum of care including both SAM and MAM. In 2019, the drought situation provided an opportunity for UNICEF to raise funds and to further strengthen the IMAM programme in the targeted 58 districts, nine of which were districts UNICEF is implementing the longer-term multisector SUN II programme. The SUN II programme also provided an opportunity for integrating IMAM programme in the 17 SUN II districts, with SAM treatment as a part of the essential actions. The objective of the IMAM programme is to reduce malnutrition-related mortality and morbidity in children under five years of age in the targeted districts through improved access to quality service delivery for IMAM and increase the proportion of children aged below five years with equitable access to and use of IMAM services through a systems strengthening approach.

Malnutrition imposes high social and economic costs. It costs African economies like Zambia between 3 and 16 per cent of Gross Domestic Product (GDP) annually. Malnutrition contributes to 45 per cent of all deaths of children under the age five.[9] The costs associated with mortality are identified in losses to national productivity. The Cost of Hunger in Africa studies reported a 1–8 per cent reduction in the national workforce due to child mortality associated with undernutrition. Significant GDP gains will be made for Zambia if the country will meet the 2025 World Health Assembly target of a 40 per cent reduction in chronic undernutrition.

[8] Global Action Plan on Child Wasting: a framework for action to accelerate progress in preventing and managing child wasting and the achievement of the sustainable development Goals. https://www.who.int/publications/m/item/global-action-plan-on-child-wasting-a-framework-for-action

[9] Black et al., 2013

Coordination and partnerships for nutrition

To ensure effective delivery of services, UNICEF worked closely with the government line ministries/agencies including the Disaster Management and Mitigation Unit (DMMU), MoH, NFNC, Ministry of Water Development and Sanitation (formally Ministry of Water Development, Sanitation and Environmental Protection), and relevant provincial and district authorities. The NGOs provided financial and in-kind contribution to the programme including supervisory support, reporting and programme oversight under the leadership of the MoH. UNICEF supported capacity building of the MoH and NGO staff, procurement and facilitation of supplies distribution, and overall programme oversight. The MoH provided overall oversight for the programme implementation and financial support.

During the period under review, UNICEF supported the NFNC to co-chair the Nutrition Coordination Group to ensure adequate coordination of the nutrition sector response. During the initial 12 months, a coordination mechanism for the drought response was established and maintained. By means of this mechanism, UNICEF ensured coordination and delivery of nutrition, drought and COVID-19 activities through the existing government structures.

UNICEF contributed to strengthening coordination through provision of technical assistance in co-leading the Nutrition Emergency Coordination Group in the development and implementation of a coherent and coordinated emergency nutrition response. Technical support was also provided for the establishment and management of the Assessment Sub-Technical Working Group, which guided the generation of evidence base decision making for drought response.

Changes observed within the past year (2020 vs 2021):

a) A new Government was elected in August 2021 and it announced a series of commitments, which could spell improvements to the nutrition funding situation and the sector.
b) For the year 2021, allocation of funding for procurement of nutrition supplies by the Government was made as contribution to the management of acute malnutrition in the country. However, this contribution did not materialise during the reporting period. UNICEF continues with its advocacy for more allocation and funding to scale up and sustain nutrition activities with the promise of increased government contribution in 2022.
c) The emergency response faced a huge shortfall of funding during the year, but thankfully thematic funds were available to mitigate the funding gap.
d) During the period under review, the MoH confirmed the third wave of COVID-19 in the country, with a daily consistent increase in the number of positive cases and deaths. This negatively impacted programme implementation including disruption and suspension of outreach activities as well as joint UNICEF-MoH monitoring activities. Fear of infection/exposure to COVID-19 deterred attendance at health facilities leading to defaulter SAM and MAM rates.
e) In 2021, the COVID-19 pandemic continued to adversely impact the food and nutrition security in Zambia. As of 31 December 2021, Zambia reported cumulative 254,274 confirmed cases with 3,734 deaths.[10] A Lancet paper estimated a global increase of 14 per cent in moderate

[10] Zambia National Public Health Institute dashboard.

or severe wasting due to the pandemic, and an estimated 30 per cent overall reduction in coverage for essential nutrition services, reaching 75–100 per cent in fragile countries.[11] This analysis has worrying implications for a country like Zambia with reduced fiscal capability, stretched and disrupted health and food systems due to COVID-19. For this reason, all forms of malnutrition, particularly acute malnutrition among children, are expected to increase, threatening the lives of vulnerable children in Zambia. This underscores the important need to scale up IMAM and maintain the continuity and quality of service delivery.

Key challenges:

- With the shrinking fiscal space in Zambia, there was inadequate government financial allocation for the nutrition programme and supplies. Funding gaps to scale-up and sustain the overall nutrition activities remained a major challenge in 2021. UNICEF continues to advocate for government allocation for the procurement of therapeutic supplies. This is to address the observed challenge of donor dependency to provide all RUTF supplies even though the Government has included RUTF in the essential drugs list, which meant the product should be prioritised for GRZ funding.
- COVID-19 pandemic continued to compromise the health system for SAM treatment in 2021. The imposed restrictions due to COVID-19 negatively impacted programme implementation causing disruption and suspension of outreach services and trainings.
- With restrictions on movement, fear of infections, suspension of services due to COVID-19 and inaccessibility due to floods, bad terrain and roads, and low community outreach services, not all beneficiaries can be reached, leading to low admission numbers and high defaulter rates sometimes.
- At the beginning of the year, heavy rains and floods were experienced, thus affecting access and utilisation of IMAM services including disruption of nutrition services, especially the outreach activities.

UNICEF comparative advantage:

UNICEF is the co-leading agency for various coordination platforms with nutrition Cooperating Partners. UNICEF establishes coordination mechanisms with the United Nations agencies, NGOs and districts to ensure effective communication and technical support by all stakeholders. Owing to UNICEF's track record in the nutrition sector and as a valued and trusted Government partner in Zambia, UNICEF successfully forged partnerships with five donors (Sweden, Irish Aid, FCDO, KfW and the European Union) and five NGOs (Save the Children International, WVI, CARE International, CRS, and PLAN) under the SUN-II programme and secured funding to support nutrition activities. Further partnerships were established with three NGOs (PLAN, WVI and People in Need) in the drought-affected districts.

[11]Child malnutrition and COVID-19: the time to act is now. Lancet. 2020; (published online July 27.) https://doi.org/10.1016/S0140-6736(20)31648-2.

Through a UN-to-UN agreement, UNICEF partnered with the UNHCR (financial and technical assistance) to support the Commissioner of Refugees, the MoH and NFNC to conduct the SENS in three refugee camps of Mantapala, Maheba and Mayukwayukwa.

UNICEF Zambia is a strategic partner in the efforts to reduce morbidity and mortality related to treatment and prevention programmes and has successfully implemented similar programmes in the past.

G. HUMANITARIAN RESULTS

This section highlights key achievements recorded under the nutrition sector for the period January to December 2021. Results presented have been achieved through donor contributions, as well as resources from UNICEF's regular programmes where necessary. The statistics and figures in the report are based on data from the MoH, UNICEF Zambia reports and reports from the districts and partners. The key focus throughout 2021 was to accelerate the implementation of nutrition activities and increase coverage of services from national to community level.

Table 1 below reflects the UNICEF-supported results against the targets set for the year 2021 for the nutrition sector:

Table 1. Summary of programme results

Zambia			**UNICEF and IPs Response**		**Cluster/Sector Response**		
Sector **Indicator | Disaggregation**		**Total needs**	**2021 target**	**Total results**	**2021 target**	**Total results**	**Change* ▲▼**
Nutrition							
# of children 6-59 months affected by SAM, admitted into treatment.	Girls		31,578	21,327[12]			
	Boys						
	women	-	-	NA			
# of children aged six to 59 months receiving vitamin A supplementation	Girls		3,299,000	31,212[13]			
	Boys						
	women	-	NA	NA			

Source: Extract from 2021 Zambia HAC annual report

[12] The figure of 21,327 highlighted against indicator 1 in Table 1 (Zambia 2021 HAC annual report) includes MAM and SAM cases reported in November 2021. Additional analysis and reporting that was done for the year January-December 2021 indicates a new figure of **14,674**, which reflect SAM admission cases only.

[13] The figure of 31,212 highlighted against indicator 2 in Table 1 was under reported. The new figure is **4,894,362** and is due to additional reporting and analysis done for the year January-December 2021 for Vitamin A supplementation and the second round of Vitamin A immunisation, which was initially not part of the HAC reporting.

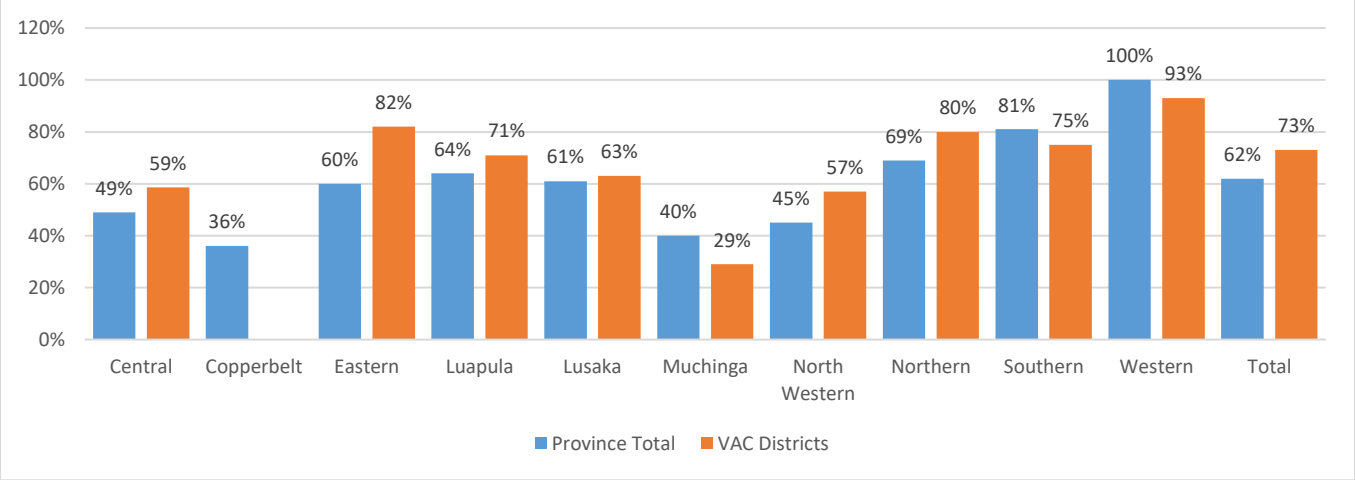
From the foregoing, the key results achieved under the nutrition sector during 2021 were as follows:

Indicator 1: # of children 6–59 months affected by severe acute malnutrition, admitted into treatment

During the reporting period, UNICEF supported the drought-affected districts with nutrition emergency support by implementing the IMAM programme and IYCF activities. Through its partners, UNICEF supported and strengthened life-saving interventions through the IMAM programme by preventing and treating cases of SAM and MAM among children under five years of age in the 58 drought-affected districts, and seven districts in Luapula province.

Nationally, a total of 1,577 (62 per cent) health facilities are providing SAM services, compared to 73 per cent in the UNICEF supported districts. This is attributed to availability of funds and supplies, capacity building of service providers, joint monitoring, and coordination with the MoH. Figure 3 below highlights the SAM treatment coverage across the provinces with a comparison coverage of the drought-affected districts in the provinces, receiving UNICEF support.

Figure 3: National Integrated Phase Classification (ITP)/OTP programme coverage in 2021



Source: Data from Health Management Information System (HMIS)

To enhance the Government and partners' capacities in delivering quality nutrition services and health system strengthening, capacity building was prioritised for health workers and volunteers. UNICEF supported the MoH in building and strengthening capacities of service providers to deliver quality nutrition therapeutic services through technical and financial support, resulting in a total of 1,573 health workers 6,802 volunteers and 100 NGO staff trained in IMAM and IYCF-E in the drought-affected districts.[14] Furthermore, training on IMAM and IYCF was organised for 130 health workers and 516 volunteers in the seven districts of Luapula province, resulting in increased coverage, scale-up of IMAM and promotion of IYCF practices in facilities and communities. The trainings also increased the pool of service providers with updated knowledge and skills on IMAM ad IYCF, including improvement in the quality of care of malnourished children

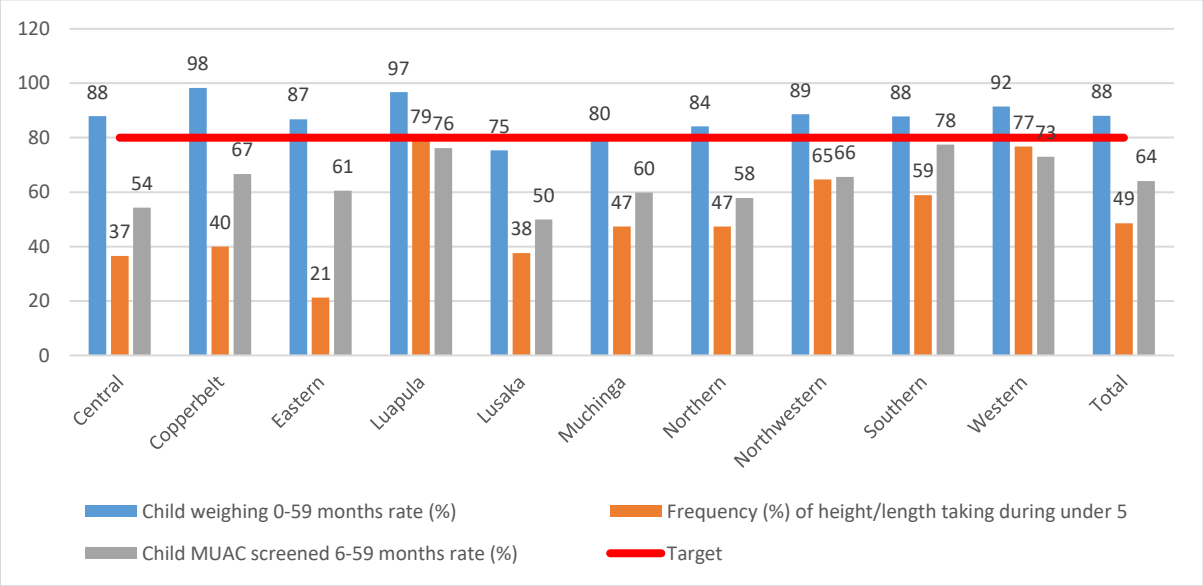
[14] The training figures are higher than COAR due to additional reporting by partner on trainings conducted.

As a result of the training, the Community Based Volunteers screened children at community level, and referred them to outreach sites, and OTP at the health facility for treatment. A monthly average of 228,227 children aged 6–59 months were screened for malnutrition. As a result, a total of 41,150 acutely malnourished (9,955 SAM and 31,195 MAM) children were identified and admitted under the IMAM programme in the 58 drought-affected districts. The programme achieved 79 per cent cure rate, 1 per cent mortality rate and 20 per cent defaulter rate for children with SAM, who were admitted and treated in the OTP. The cure rate is above the World Health Organization (WHO)/Sphere Minimum Standard threshold of >75 per cent. The mortality rate for SAM children of 1 per cent was below the WHO threshold and programme target of 10 per cent and defaulter rate of 20 per cent was above the WHO threshold of <15 per cent.

For children with MAM, an 84 per cent cure rate, 0 per cent mortality and 16 per cent defaulter rate was observed. MAM children were admitted and treated through the expanded criteria using RUTF. The cure rate is above the WHO standard threshold of >75 per cent. The mortality rate for MAM children of 0 per cent was below the WHO threshold and programme target of 16 per cent and defaulter rate of 14 per cent was slightly above the WHO threshold of <15 per cent.

At the national level, an average of 674,751 children were screened between January and December 2021. A total of 14,674 SAM children and 47,362 children with MAM were admitted and treated in OTP compared to 12,981 SAM and 11,258 MAM in 2020.[15] The MAM children were treated in OTP under the expanded programme. Like in 2020, SAM recovery rate remained static at 78 per cent in 2021 and at 84 per cent for MAM. The cure rate is above the WHO threshold of >75 per cent. The defaulter rate for SAM and MAM were 20 per cent and 16 per cent, respectively, both above the WHO threshold of <15 per cent. The SAM mortality rate was 2 per cent below the WHO threshold of <10 per cent. There was no mortality recorded for MAM children.

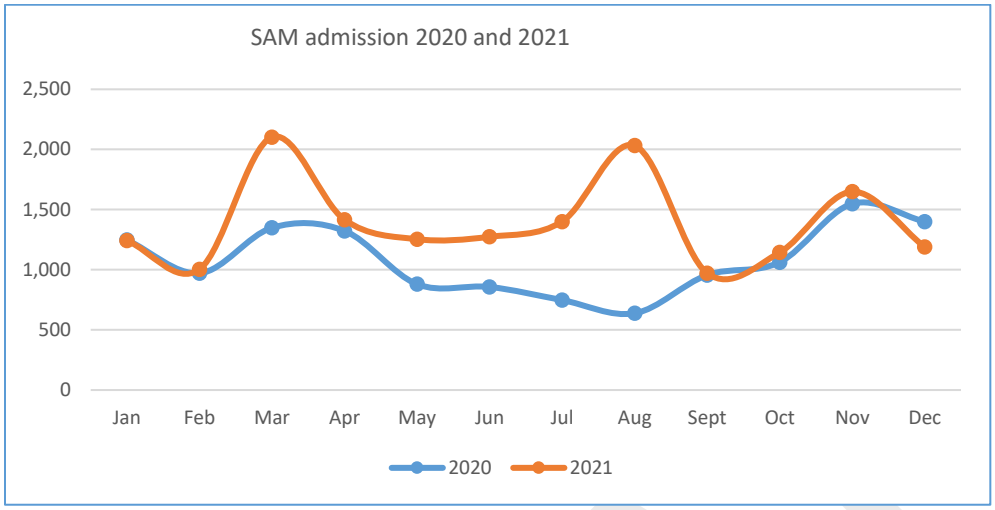
Figure 4: National Nutrition assessment in children under 5 (%) - 2021



Source: Data from Health Management Information System (HMIS)

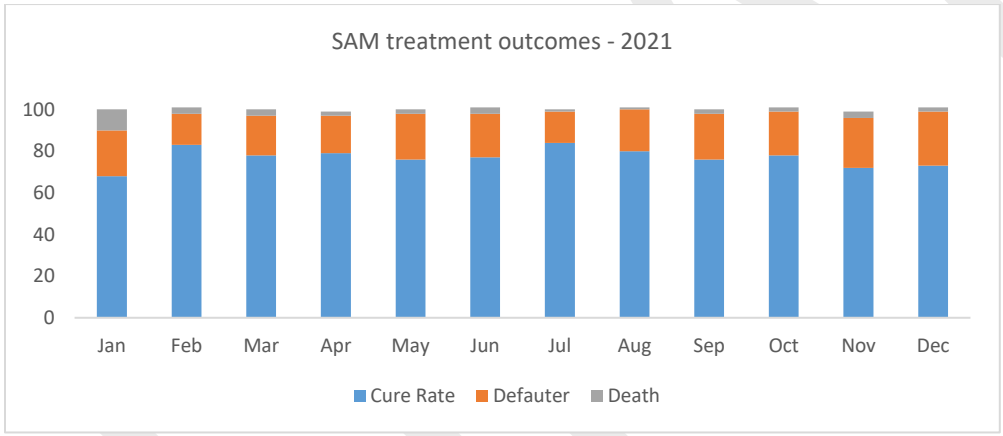
[15] The IMAM reported figures are higher than COAR due to additional reporting by partner

Figure 5: National SAM admission 2020 vs 2021



Source: Data from Health Management Information System (HMIS)

Figure 6: National SAM treatment outcomes - 2021



Source: Data from Health Management Information System (HMIS)

The outcome indicators for the IMAM programme were achieved except for defaulter rate. The high defaulter rates for both SAM and MAM treatment were attributed to: reduced outreach activities due to COVID-19 restrictions, a nomadic lifestyle, non-compliance to treatment duration by beneficiaries leading to self-discharge when deemed cured, prioritising fishing and farming during the agriculture season, and problems accessing nutrition centres either due to long distances or difficult terrain.

Volunteer training in North-Western province supported by thematic funds UNICEF/Zambia2021/Namanje

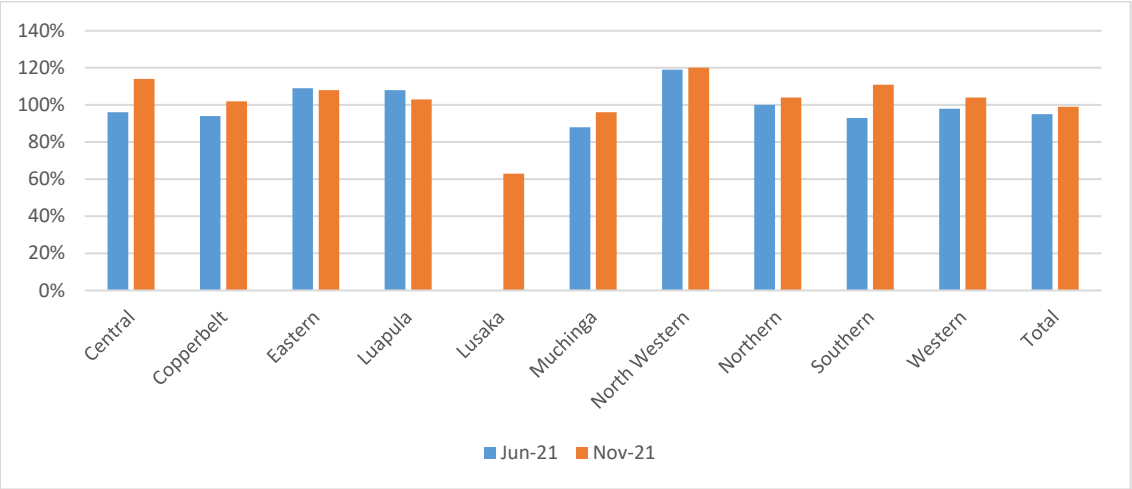
Indicator 2: # of children aged 6–59 months receiving Vitamin A supplementation

UNICEF continued to play a key role in the nutrition sector by enhancing routine outreach services, such as GMP, Maternal, Infant and Young Child Nutrition (MAIYCN), Vitamin A supplementation, and health and nutrition counselling. UNICEF supported Vitamin A supplementation by providing 5,529,500 Vitamin A capsules (200,000 IU) and 735,300 Vitamin A capsules (100,000 IU) to cover the two rounds of child health week campaigns in 2021, respectively. This facilitated the MoH to reach 4,894,362 children aged 6–59 months with Vitamin A supplementation during the first round in June 2021, and the second round in November 2021.

The Vitamin A was provided as routine Vitamin A supplementation through health facilities and during child health week enabling health workers and community volunteers to reach out to communities. The child health week activities were implemented at all health facilities and community outreach points in every district of the country. The child health week activities were conducted amidst the COVID-19 pandemic and measures were put in place to prevent the spread of virus. This included updating and issuance of the document “Infection Prevention and Control (IPC) COVID-19 at service point” by the MoH to all facilities and service providers including close monitoring. UNICEF continues to support the MoH to deliver bi-annually Vitamin A supplements to children aged 6–59 months during child health week through capacity building, mass media advertisement and supporting operational costs through district level plans. The strategy to complement routine Vitamin A supplementation through health facilities during child health week helps to ensure full coverage of the targeted children. Figure 7 below highlights the national

Vitamin A coverage with all districts having an average of more than 90 per cent coverage for the two rounds of the child health week.

Figure 7: Vitamin A Supplementation Coverage (%) 2021



Source: HMIS (reported by districts, health facilities, partners from routine and child health week activities)

During the period under review, UNICEF provided both technical and financial support to facilitate alignment of the IMAM and IYCF-E training package with recent global updates including and printing of materials that facilitated the rollout of capacity building activities

The first national IMAM data review workshop was organised in Zambia in February 2021 aiming to improve data reporting, data quality, data analysis, and utilisation at the district and facility levels. UNICEF ensured provision of technical and financial support for monitoring and evaluation component. UNICEF and the MoH conducted an orientation of MoH staff in data audit leading to improvement in reporting and data quality in the 58 districts.

To support service delivery, UNICEF procured additional 2,800 cartons of RUTF and facilitated distribution of supplies and equipment to over 58 drought affected districts and Luapula province for the management of acutely malnourished children. Supplies were prepositioned in the districts to better prepare for emergencies, in anticipation of access issues during the rainy season.

Stock taking at the warehouse, of the nutrition supplies for treatment and prevention of malnutrition procured with support from UNICEF and other donors before delivery to various districts and health facilities.
©UNICEF/Zambia 2021/Phyllis Oyugi

For the reporting period, COVID-19 continued to compromise SAM treatment. The imposed restrictions due to COVID-19 negatively impacted programme implementation. It caused disruption and suspension of outreach services and trainings. The services at the health facility and outreach were also affected due to movement restrictions and fear of infection/exposure to COVID-19.

Provision of COVID-19 mitigation supplies and remote monitoring helped ensure overall consistency and continuity of service delivery. Additionally, Information, Education and Communication materials on COVID-19 were printed and distributed to service providers and health facilities. Trainings were adjusted to ensure IPC messaging, and use of remote programming and monitoring was employed in instances where physical presence was not possible.

Family MUAC approach was adopted in Lusaka district. A total of 241 health workers and 897 volunteers were trained on family MUAC approach. The service providers cascaded the training to 284,930 caregivers. As a result, the caregivers were able to identify early signs of malnutrition in their children using an MUAC tape and refer malnourished children to health facilities for appropriate treatment. Upon availability of funding, the approach will be rolled out to other districts to reduce contact and prevent COVID-19 infections.

Several factors contributed to the programme achievements of the two indicators/results:

- Funding from various donors, involvement of NGOs during implementation and overall oversight of the programme by the MoH was key. A six months no-cost extension was granted by ECHO from 1 April 2021 to 31 September 2021 and enabled the completion of the programme activities. The human resource capacity building through training of health

workers and volunteers and the availability of provision of nutrition supplies for treatment of malnutrition were major contributors to the achievement.

- Joint planning, monitoring, mentorship, and supportive supervision also ensured health system strengthening. Moreover, during the extension period, the COVID-19 related restrictions were relaxed and enabled outreach activities, such as screening and identification of malnourished children, referrals, follow ups and growth monitoring to take place with little distractions. Community volunteers were able to carry out nutrition activities at community level and conduct IYCF sessions for beneficiaries. Nutrition services were also accessible to beneficiaries both at the facility and community level. Support on monitoring and data management, which included capacity building of health workers on data collection and reporting, mentorship, data quality audit reviews, joint monitoring, workshops, feedback sessions and availability of data reporting tools increased the reporting rate and data quality.
- PPEs, such as masks, gloves and hand sanitisers for service providers and facilities were procured and distributed to ensure infection prevention. Procurement and distribution of volunteer materials (boots, aprons) enabled the volunteers to effectively conduct their activities.

With the shrinking fiscal space in Zambia, there was inadequate government financial allocation for the programme and supplies. UNICEF continues to advocate for government allocation for the procurement of therapeutic supplies to address the challenge of donor dependency.

Slow programme scale up and temporary suspension of outreach activities due to COVID-19 restrictions, rains and floods have affected the coverage of IMAM, and consistency and continuity of service delivery. There is need for increased trained human resource who can adequately cover the population, including vast catchment areas and dispersed communities as observed especially in Western province.

Lessons learned and innovations:

- Provision of systematic support from the districts to community level structures has allowed the programme to be more responsive to expressed needs, especially at community level. More efforts on integration across sectors are required at all levels to improve programme's effectiveness.
- Collaboration and leveraging resources from other stakeholders remain effective strategies for maximising resources.
- Adaptive programmatic approaches with innovation, such as Family MUAC approach and other simplified approaches for scale-up should be considered to increase coverage of early identification and referrals of malnourished children and to empower caregivers. The community volunteers are already trained in MUAC and will be able to train the caregivers.
- Sustained financial and technical support is important and needed for health system strengthening, especially at district and community levels, with an aim of integrating SAM prevention at all levels of service delivery.

- Limited investment from both the Government and partners on nutrition activities especially IMAM derails the scale up of the programme.
- Lobbying for inclusion of SAM treatment as part of the high-impact nutrition interventions package in the Intervention Pyramid has ensured that preventive and curative nutrition services are now part of the Pyramid, leading to better humanitarian-development nexus.
- Capacity building of government staff in SMART methodology in 2020 facilitated efficient supervision of the SENS. This reaffirmed that investing in government staff to effectively support implementation of these surveys could help reduce costs.

a. HUMANITARIAN RESULTS CASE STUDIES

Tackling malnutrition in Zambia using existing community structures

Top level results: Through the Global Humanitarian Thematic Funding (GHTF) and following the use of the community structures in the fight against malnutrition, an estimated 4,632 SAM children were admitted in Luapula province out of the 14,674 SAM children nationally. Through the contributions of the thematic funding, the rate of wasting among children 6-59 months of age in Luapula province stands at 4 per cent compared to 7 per cent, previously recorded. Some cases were not reported and there were no skilled volunteers within community structures and high cases of SAM with complications reported. This was envisaged to help reduce acute malnutrition or wasting in the district.

Issue/background: Between 2017 and 2021, Chifunabuli district in Luapula province, had continued to record more cases of acute malnutrition. On average, 20 cases of SAM with complications were admitted to the ITP on a monthly basis. Due to the unavailability of skilled community volunteers within the community structures to track and manage acute malnutrition without complications, some cases were not reported. To increase the identification and number of SAM children for admission and treatment, the district advocated for support to scale-up the IMAM interventions through the community structures. Through the IMAM interventions, it is envisaged that acute malnutrition or wasting in the province would reduce.

Resources required/allocated: Resources required included funding needs for training of health workers, community volunteers and for the mobilisation and sensitisation of community leaders. Outreach sessions were conducted at community level including focused meetings. The community participated in IMAM scale up meetings supported by UNICEF and accessed financial support from UNICEF through thematic funding which was used to train health workers and volunteers in IMAM and MIYCN. Overall, the programme activities were supported through thematic funds which bridged the funding gaps.

Community volunteers supporting nutrition activities in the community
©UNICEF/Zambia 2021/Namonje

Progress and results: Volunteers and community leaders participated in IMAM scale up meetings. This motivated the service providers to scale up and embarked on intensifying community sensitisation through community *indaba**s,***[16] with traditional leaders and other stakeholders, integrating outreach services and promoting breastfeeding. This was aimed at increasing case finding rate through MUAC screening as well as increasing the number of SAM children identified and admitted for treatment.

With the provision of thematic funding, and following the use of the community strategy, an estimated 4,632 SAM children were identified and admitted for treatment in Luapula province out of the 14,674 SAM children nationally. These children were screened by trained volunteers at community level during outreach activities, identified and referred to health facilities for treatment. This contributed to indicator 1 results on: *# of children 6-59 months affected by severe acute malnutrition, admitted into treatment.*

Additionally, as a result of these efforts, there has been a reduction in the admission of severely malnourished children with complications to the ITP **(***January2018=26, 2019=23, 2020=22, 2021=13,)* in the province. This means that more cases of acute malnutrition are being traced and managed in the community. The MUAC screening rate has also increased from less than 50 per cent to currently over 95 per cent.

Trained community volunteers, health workers and beneficiaries working together to manage malnutrition
©UNICEF/Zambia 2021/Fred Chalula

Criticality and value addition: Opportunities available at community level included *indabas* and existing healthcare programmes which enabled to inform five chiefdoms in Chifunabuli district about the services available. This also helped to strengthen community participation in GMP activities for early detection of malnutrition in children, thereby preventing deterioration. Children who are malnourished delay to get treatment because of poor health seeking practices by the community, resulting in increased malnutrition and the complications that accompany it. These children are best identified and referred to health facilities for treatment through community outreach activities Integrated outreach services also provided an opportunity to sensitise caregivers on early signs of malnutrition and early referral of SAM children for treatment before it gets complicated. Involvement of traditional leaders also proved to be more effective in increasing the uptake of IMAM/MIYCN service.

[16] Meeting to discuss a serious topic

Challenges and lesson learned:

Challenges

The main challenge faced included inadequate resources to systematically carry out sensitisation sessions and outreach activities including growth monitoring across all districts in Luapula province and nationwide. Other challenges included lack of motivational materials such as boots, aprons, identification cards and bicycles for community volunteers. To mitigate the challenges, initiatives to mobilise resources should be in place to ensure continuity of activities. Community volunteers should also be well motivated to enable them to conduct their work effectively. Additionally, more volunteers need to be trained to adequately deliver quality services to children and to cover, in some cases, the vast catchment areas.

Lesson learned

Children who are wasted are at high risk of mortality compared to other children. It is imperative that vulnerable children at risk of malnutrition and those malnourished are identified early and managed at community level before they get complications. This underpins the importance of community structures and health systems strengthening at community level.

Moving forward: There are plans to intensify sensitisation activities through the involvement of traditional leaders. There are also plans to increase outreach activities at the community level using the trained volunteers. Both initiatives are aimed at strengthening working relationships among the community leaders, trained volunteers, and the health workers to provide timely and quality nutrition services to vulnerable children and women and "leaving no one behind." The remaining thematic funds which expire in 2022 will be used to implement IMAM activities. To mitigate the funding gap, fund raising efforts will be intensified in 2022 to ensure continuity of the IMAM interventions in the country and sustain the gains made.

To increase the number of SAM children identified and admitted for treatment and to contribute to systems strengthening, the national scale up and replication of the IMAM initiative is recommended.

H. RESULTS ACHIEVED FROM HUMANITARIAN THEMATIC FUNDING

Indicator 1: # of children 6–59 months affected by severe acute malnutrition, admitted into treatment.

Through the thematic funds, UNICEF supported the MoH and provided life-saving nutrition interventions through the IMAM rollout in 113 drought-affected districts (9 in central province and 4 in North Western province). A total of 315 health workers and 830 volunteers were trained in IMAM and IYCF-E to ensure IMAM scale up and promotion of IYCF practices. As a result, a monthly average of 163,548 (57 per cent) children under five years of age were screened, with 4,806 identified as acutely malnourished against a target of 34,436. Out of these, 1,167 children were identified as severely malnourished and referred to OTP and 3,639 children as moderately malnourished and treated in OTP using the expanded criteria. Out of the 1,167 SAM children, 80 per cent were cured/recovered and discharged, 6 per cent did not survive and 14 per cent

defaulted. The cure/recovery rate is above the WHO/Sphere Minimum Standard threshold of >75 per cent. The mortality rate for SAM children of 6 per cent was below the WHO threshold and programme target of 10 per cent and defaulter rate of 14 per cent was below the WHO threshold of <15 per cent. Similarly, of the 3,639 MAM children who were admitted and treated using the expanded criteria with RUTF, the cure rate was 83 per cent, with mortality rate of 0 per cent and defaulter rate of 17 per cent. The mortality rate is below the WHO threshold and target of the programme of <3 per cent.

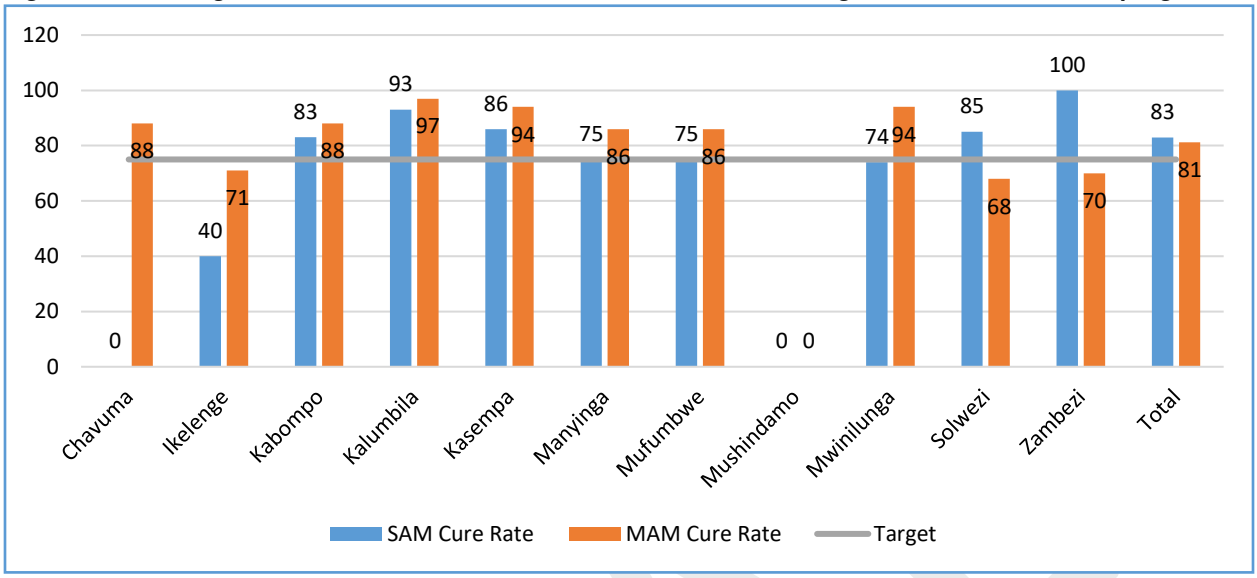
North-Western province

A total of 304 SAM and 882 MAM children under five years of age were admitted in OTP in North Western province against a target of 1,147 SAM and 2,295 MAM. Figure 8 and Figure 9 below shows the SAM and MAM outcome indicators for North Western province and including the four districts supported by UNICEF (Chavuma, Zambezi, Kabompo and Mufumbwe). During the period under review, the province recorded an overall cure rate of approximately 82.9 per cent and 81.2 per cent for SAM and MAM, respectively. This was above the WHO threshold of > 75 per cent.

Figure 8: Children 6–59 months with SAM admitted in IMAM programme in North Western province – 2021

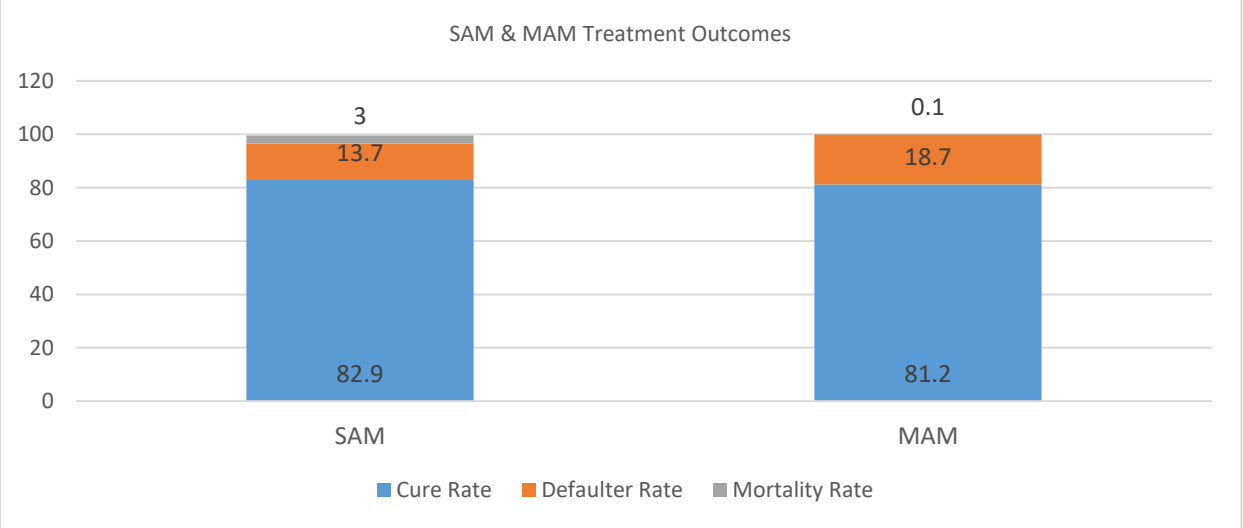
Source (HMIS)

Figure 9: Percentage of children 6–59 months with SAM and MAM discharged as cured from IMAM programme



Source: HMIS

Figure 10: Outcome indicators (%) of children 6–59 months with SAM and MAM 2021 – North Western province

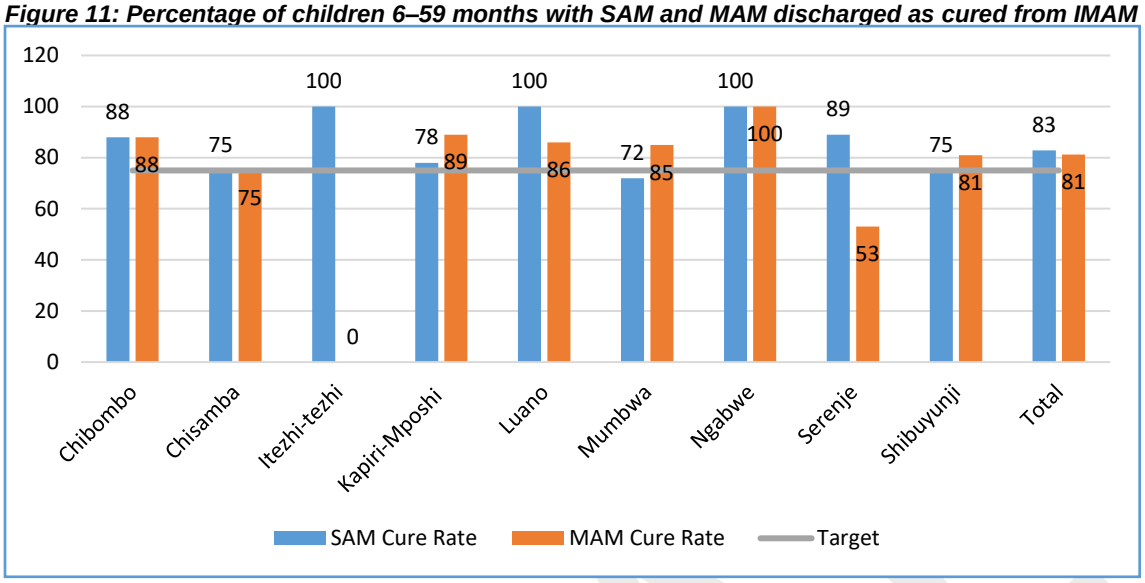


Source: HMIS

Central province

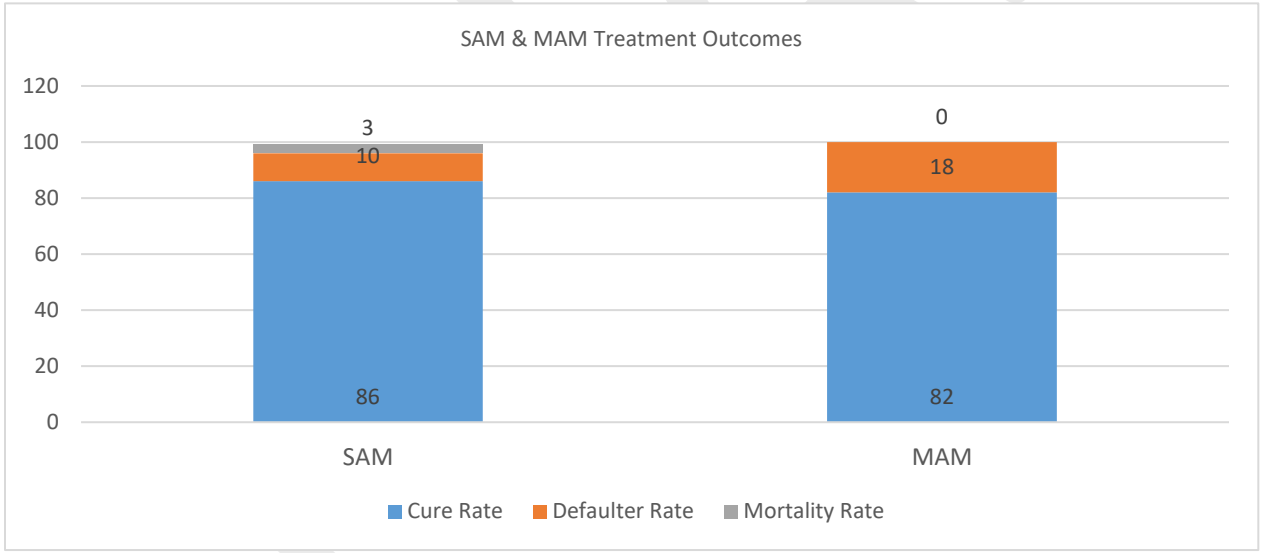
A total of 863 SAM and 2,757 MAM children under five years of age were admitted in OTP in Central province against a target of 10,027 SAM and 20,966 MAM. Figure 11 and Figure 12 below indicate the SAM and MAM outcome indicators for Central province. The province recorded an overall cure rate of approximately 86 per cent and 82 per cent for SAM and MAM, respectively in 2021. This was above the WHO threshold of > 75 per cent.

Figure 11: Percentage of children 6–59 months with SAM and MAM discharged as cured from IMAM



Source: HMIS

Figure 12: Outcome indicators (%) of children 6–59 months with SAM and MAM – Central province – 2021



Source: HMIS

A monthly average of 34,780 mothers with children under two years old received IYCF-E counselling with a 90 per cent early initiation to breastfeeding recorded in the 13 districts during the year.

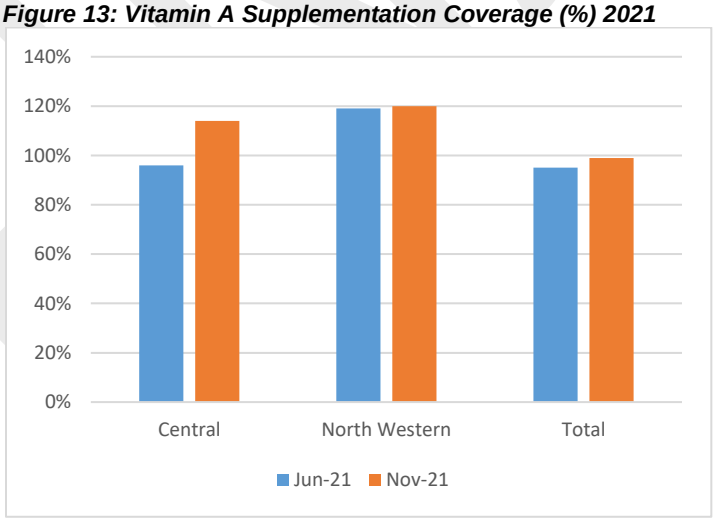
Low admission rates in central and North Western province are attributed to delays in training of health workers and volunteers and suspension of outreach activities due to COVID-19 restrictions, rains and floods. Most of the areas in this province are inaccessible for almost five months due to flooding. However, despite these challenges, considerable progress was made with a recorded increase in the coverage of SAM treatment.

Funding from thematic was also utilised for capacity building of the health workers and volunteers including supportive supervision and monitoring visits for the 14 districts. Joint planning, monitoring, mentorship and supportive supervision ensured health system strengthening. The COVID-19 related restrictions were relaxed and enabled community outreach activities and full resumption of nutrition services at facility level. Nutrition services were also accessible to beneficiaries both at the facility and community level. In addition, the availability of supplies and equipment were essential in the management of malnourished children and in the improvement of the quality of services accessed.

Indicator 2: # of children aged 6–59 months receiving Vitamin A supplementation

As previously mentioned, UNICEF continued to play a key role in the nutrition sector by enhancing routine outreach services, such as GMP, MAIYCN, Vitamin A supplementation, and health and nutrition counselling. UNICEF supported Vitamin A supplementation through health facilities and during child health week activities, enabling health workers and community volunteers to reach out to communities. The child health week activities were implemented at all health facilities and community outreach points in every district. During the period under review, child health week activities were carried out amidst the COVID-19 pandemic and measures were put in place to prevent the spread of the virus. This included updating and issuance of the document “IPC of COVID-19 at the service point” by the MoH to all facilities and service providers and close monitoring of the exercise. Figure 13 below indicates the Vitamin A coverage in North Western and Central province, with both provinces having an average of more than 90 per cent coverage for the two rounds of Vitamin A supplementation.

Figure 13: Vitamin A Supplementation Coverage (%) 2021



Source: HMIS

In conclusion, although progress was made by utilising emergency funds, SAM treatment should be prioritised in the development context with sufficient funding to ensure sustainability of the gains made.

Continued advocacy for SAM treatment services is required and needs to be systematically addressed, including advocacy with donors for funding for procurement of feeds, equipment and capacity building including advocacy for increase in government budget allocation for IMAM.

a. THEMATIC HUMANITARIAN FUNDING CASE STUDIES

Thematic humanitarian funding case study 1

Capacity building of IMAM service providers to delivery of quality services for SAM children

Top level results: The GHTF were critical in provision of life-saving nutrition interventions in, North Western and Central provinces. A total of 315 health workers and 830 volunteers were trained on IMAM and IYCF, critical in the management of SAM children. As a result, 1,167 SAM children under-five were identified by the trained volunteers at the community level and referred to health facilities where they were managed and treated by the trained health workers. Of these, 72 per cent children were cured and their lives saved.

Issue/background: The 2019 vulnerability assessment results revealed increase in wasting, with 58 drought-affected districts, identified in need of emergency nutrition response. A bottleneck analysis conducted in 2019 also identified that availability, accessibility, and quality of SAM treatment services remains poor nationwide, with only 6 per cent of health workers trained on IMAM, and 24 per cent of health facilities providing SAM management. UNICEF supported the MoH to provide capacity building of service providers in response to high wasting as part of the overall health sector response in reducing the effects of the drought in the drought-affected districts.

Resources required/allocated: Funds were required for training of volunteers at community level and health workers at facility level. A total of US$ 154,053 from the GHTF was specifically used for the training of health workers and community volunteers in 13 districts. The health workers trained included MoH staff at the health facilities managing malnourished children. The community volunteers support IMAM outreach activities, referral of malnourished children, home visits and counselling of mothers/caretakers.

Progress and Results: Thematic funding was used for the capacity building of service providers in IMAM and IYCF. A total of 315 health workers and 830 volunteers were trained. The training of health workers and volunteers facilitated the screening of 1,167 children under five and reaching under-five children who were severely malnourished/wasted. These children were at risk of not surviving but were provided with timely IMAM interventions through the trained health workers and volunteers.

Criticality and value addition: Thematic funds were flexible and could be sent as direct cash transfers leading to timely disbursement of funds and commencement of trainings as planned. Capacity building of the health workers ensured increase in the human resource for managing malnourished children as only 6 per cent were trained in IMAM nationally. There has been an increase in coverage of SAM management with each facility in the 13 districts having at least two health workers trained in IMAM. With capacity building of volunteers, there was increase in outreach activities which include GMP. Overall, this resulted in enhanced quality of treatment.

Challenges and lesson learned:

Challenges

Availability of funds to train adequate numbers of health workers and volunteers has been a major challenge. To mitigate the challenge, an average of two health workers and five volunteers were trained on IMAM and IYCF per health facility in the 13 districts. However, to adequately cover all the designated zones, there is need for additional trained volunteers.

Lessons learned

- Community volunteers offer a critical link between the community and health facility in the management of wasting. The volunteers identify and refer malnourished children to facilities and follow them up at the community level. They also provide nutrition counselling to beneficiaries for preventing of malnutrition.
- Proper management of malnourished children through skilled personnel is critical as wasted children have 9-12 times risk of mortality compared to other children. There is need for continued capacity building and mentorship of health workers and volunteers to increase coverage and provide quality nutrition services.

Moving forward: UNICEF will fundraise for continued capacity building of additional health workers and volunteers and mentorship of the ones trained. The trained service providers are providing orientation to others once they are trained to share knowledge and skills acquired. With funding availability, there is need to increase the number of trained service providers due to attrition, and the numbers trained are not sufficient to adequately manage the cases of malnutrition. This contributes to health systems strengthening both at facility and community level leading to sustainability.

Volunteer training in North Western province supported by thematic funds (Credit: (©UNICEF/Zambia 2021/Namonje)


Right: Volunteers training on IMAM. Central province
©/UNICEF/Zambia 2021/Mercy
Left: Health workers training on IMAM-Central province
©UNICEF/Zambia2021/Mercy

Thematic humanitarian funding case study 2

Technical support and data quality management to measure the impact of nutrition services

Top Level results: The GHTF were critical in provision of life-saving nutrition interventions in Northern and Central provinces contributing to Goal area 1: *every child survives and thrives.* Technical support and capacity building on data management was provided, with a total of 315 health workers trained in data management. A total of 11 data audit reviews were also conducted in the two provinces. As a result, 1,167 children under-five with SAM were admitted in the IMAM programme and had their data and information timely reported in the HMIS system for analysis and programming to enhance service delivery. With this effort, the programme reporting rate increased from 69 per cent to 98 per cent.

Issue/background: The IMAM programme target SAM services with a coverage of 70 per cent. However, as of 31 December 2020, data analysis revealed only 40 per cent coverage. A nationwide IMAM programme data review (first one) conducted in February 2021 identified several challenges contributing to low coverage and poor reporting. These included programme data not uploaded in the HMIS system, incomplete submissions, inadequate capacity to generate and utilise data, untimely reporting, inadequate linkages and understanding between IMAM report forms and other data sources. Data audit reviews exercise including data management trainings were prioritised and undertaken by the MoH supported by UNICEF in North Western and Central provinces.

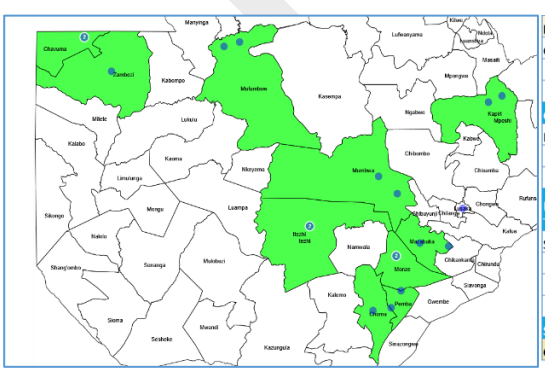
Resources required/allocated: Funding was required for nationwide data review workshop, data review trainings for MoH health workers, and data review field exercise and mentorship at facility level for MoH staff. The data audit review exercise was carried out in North Western province (Mufumbwe, Kabompo, Zambezi, and Chavuma districts) in Central province (Itezhi tezhi, Mumbwa and Kapiri Mposhi), and in Southern province (Mazabuka, Monze, Pemba, and Choma districts). The targeted facilities where for data audit reviews included one high volume rural facility and one high volume urban facility in each district. The audit data teams consisted of one Child Health and Nutrition staff, UNICEF and provincial and district Nutritionists including one

Monitoring and Evaluation person from the province. The exercise was led by the MoH from national and provincial level and supported by UNICEF. Subsequently, data audit trainings and data audit review exercises were scaled up to all facilities in four districts in North-Western province and nine districts in Central province with the support of the GHTF. A total of US$7,180 was utilised for the trainings and audit review exercises.

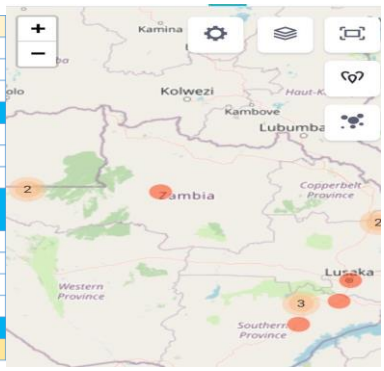
Progress and results: A total of 315 health workers were trained in data management. Technical support and physical data audit reviews were carried out in 22 facilities in 11 districts of North-Western and Central provinces. As mentioned earlier, the target facilities included one high volume rural facility and one high volume urban facility in each district. The exercise included review of data tools, human resource, inventory, physical supply, and commodity verification. Through the GHTF, improved data management was noted and contributed to the admission of 1,167 SAM children in the IMAM programme. Nutrition data and information details on these children was also analysed and reported by the trained health workers.

As a result of the technical support and data management, the reporting rate increased from 69 per cent to 98 per cent. The quality of data has improved and the IMAM programme data is being used for monitoring the nutrition situation, and to improve the management of the SAM children admitted to ensure the best outcome.

Left: Data audit review at a facility in Central province
©UNICEF/Zambia2021/Phylis Oyugi
Right: Training of health workers i Shibuyuji, Central province
©UNICEF/Zambia2021/Mercy



Province	District	Total
Central	Itezhi Tezhi	2
	Kapiri Mposhi	2
	Mumbwa	2
Central Total		**6**
North Western	Chavuma	2
	Mufumbwe	2
	Zambezi	1
North Western Total		**5**
Southern	Choma	2
	Mazabuka	2
	Monze	2
	Pemba	2
Southern Total		**8**
Grand Total		**19**



Facilities visited in the first data audit review April 2021 and real-time status and data using KOBO app

Health worker at Lukoma rural health facility with the IMAM monitoring and evaluation tools during data audit review exercise ©UNICEF/Zambia 2021/Phyllisoyugi

Technical support and supervision at the stores in Central province to check on supplies and documentation ©UNICEF/Zambia 2021/Phyllisoyugi

Criticality and value addition: Technical support and data management for the IMAM programme was critical because of the need to have available IMAM programme data that is representative of the situation on the ground. The support was also critical to enable monitoring of the IMAM programme implementation progress.

As a result of the technical support, training in data management and data reviews, IMAM programme data is being submitted timely from all points of service delivery at 98 per cent reporting rate.The quality of data has improved and the MoH is supporting the facilities to sustain the quality.Compared to the period before the data management support, the districts and facility staff now have capacities to visualize and analyse the IMAM programme data. More than 60 per cent of the facilities are displaying nutrition data at facility level and utilising it with the aim of reaching 100 per cent utilisation of data at facility level by end of 2022. The IMAM programme data is also being used for monitoring the nutrition situation, planning and programme improvement including development of workplans and quantification of supply needs in supported districts thus improved forecasting.

Challenges and lesson learned:

Challenges

The main challenge faced was insufficient funds to conduct technical supervision, data audit reviews and capacity building on data management in all the supported districts. Three provinces were first identified and prioritised for the exercise. However, thematic funds enabled the scaling up of the exercise to all facilities in the districts of Central and North-Western provinces.

Lesson learned

Availability of quality and reliable IMAM programme data is critical for enhancing effective decision making at various levels of the programme implementation.

Moving Forward: With the ending of the emergency funding support from FCDO and ECHO in 2021, the funding for the component on monitoring and evaluation of the IMAM programme has been exhausted. Thematic funding will be used to support this component as UNICEF Zambia fundraises for support for the nutrition IMAM programme. With funding, there are plans for periodic data audit reviews and review meetings at health facility and district level. This is to ensure timely reporting, sustain the quality of data being generated, and use the data to monitor the nutrition status at facility and district level and programme performance. The information generated will also be used for programme planning at district level and ensure nutrition is given the priority as other sectors. It is hoped that this initiative can be replicated nationally if funding is available.

I. ASSESSMENT, MONITORING AND EVALUATION

Results of UNICEF's humanitarian contributions are monitored through the annual reporting systems including the Country Office Annual Report (COAR), Strategic Monitoring Questions and the Results Assessment Module. To strengthen the programme monitoring, the nutrition monitoring tools (IMAM registers, referral forms, inpatient and outpatient treatment cards) were reviewed, updated, and aligned with the most recent updates in IMAM. This was done to ensure utilisation of tools at various levels including doctors, nurses, and community volunteers. Tools for monitoring and evaluation were procured and distributed to the districts to support data collection, reporting and supervision. With support from UNICEF, there has been an upgrade of software and hardware of the nutrition reporting database at the MoH, resulting in the overall report submission rate improving nationally from 60 per cent to 98 per cent.

UNICEF and the MoH also instituted a continued training and mentorship support on data management, monitoring and reporting for the teams in both the MoH and NGOs. This was aimed to address the challenges relating to the low reporting rates, improve data quality and utilisation at district and facility level. The MoH through the information management focal point, provincial and district MoH officers and NGOs worked together at the national, provincial, district and health facility level to support the data management component. UNICEF supported the MoH on data management and data quality audits leading to an increase in the reporting rate from 60 per cent to 98 per cent, and a marked improvement in data quality. Data officers from the MoH, NGOs, NFNC, DMMU and learning institutions were trained on nutrition information system and data

management including the Health Management Information System (HMIS), nutrition database and the use of KOBO tool—an android-based tool to collect data. UNICEF strengthened the overall monitoring and evaluation system. Nutrition information can now be accessed in all 116 districts in the District Health Information System 2 (DHIS2). Ten Provincial Senior Information Officers were oriented on nutrition indicators and tools to rollout Nutrition Information Systemin districts.

Programme monitoring was conducted as per agreed workplans and programme results framework. Through programme visits, progress towards achievement of planned results, challenges and mentorship was provided. At the height of the COVID-19 pandemic, the joint MoH supportive supervision, mentorship and quality monitoring of services was replaced mostly with remote monitoring. A few physical joint field monitoring visits were conducted by UNICEF, the MoH and partners.

The Harmonised Approach to Cash Transfers Framework (HACT) assurance activities, in addition to programme visits were conducted on UNICEF partners. A micro assessment and spot check was conducted for People in Need, WVI and the MoH. An audit was also conducted for WVI. UNICEF ensured that recommendations from the assurance activities were addressed by partners and facilities.

To improve evidence-based decision making, UNICEF supported mainstreaming the nutrition indicators in DHIS2, which made nutrition information accessible in all 116 districts. UNICEF supported a National Food Consumption Survey and Micronutrient Assessment. The results of the assessment will be used for evidence-based decision making, inform planning and programming of micronutrient strategies. The results will also guide the revision of strategy for micronutrient deficiency prevention and control in the country.

As part of efforts to strengthen and support evidence generation, a SENS was conducted in three refugee camps: Mantapala (Nchelenge), Mayukwayukwa (Kaoma) and Maheba (Solwezi). The findings will continue to inform the development of programme strategies and interventions to sustainably improve the livelihoods, nutritional and health status of the refugee population. UNICEF together with the MoH and UNHCR supported the survey both technically and financially and ensuring the survey was conducted according to the required standards, timeline and efficiency in data entry and analysis, as well as report writing.

J. FINANCIAL ANALYSIS

For the year 2021, UNICEF supported the MoH to implement and scale up nutrition activities in Zambia. UNICEF through its partners, supported and strengthened life-saving interventions to ensure effective service delivery. Thematic funding, UNICEF partners and UNICEF internal funding supported various programme components including the procurement of supplies, monitoring, printing of materials and capacity building.

The overall emergency response in all the 58 drought-affected districts was financially supported by the thematic funding, through FCDO, ECHO and CERF. Under the SUN-II programme, the

partnership of five donors (SIDA, Irish Aid, FCDO, KfW and the European Union ensured financial support for malnutrition prevention and treatment services in 17 districts. Partnerships were forged with three NGOs (Plan International, WVI and People in Need) to facilitate IMAM scale up in drought-affected districts. The NGOs also provided financial and in-kind contribution to the programme

The thematic funds complemented the support to the IMAM programme and mitigated the funding gap to the emergency response during the period under review.

Table 1 below highlights the overall Zambia funding needs and status by sector to support the humanitarian response.

Table 1: Funding Status by Sector

Sector	Requirements	Funds available							Funding gap	
		Humanitarian resources received in 2021 (SM)	Other resources received in 2021 (OR)	Other resources used in 2021	Humanitarian Resources available from 2020 (Carry-over)	Other resources available from 2020 (Carry-over)	COVID-19 Humanitarian Requirements (US$)- as part of 2021 overall HAC requirement	COVID-19 HAC funding available	US$	%
Health	1,650,000	1,899,143	5,449,967	4,372,547	334,090.24	655,421.83	1,650,000	9,669,609	(5,699,110)	345%
WASH	6,000,000	33,450	461,250	3,308,144	669,378.67	708,750.00	3,700,000	1,203,450	5,505,300	92%
Nutrition	3,350,000	332,615	-	0	1,007,218.22	-	1,000,000	0	3,017,385	90%
Education	10,900,000	5,576	2,357,630	7,756,865	190,477.64	5,729,726.31	10,900,000	8,277,832	8,536,794	78%
Child Protection	800,000	-	32,978	248,234	1,044.38	-	700,000	34,021	767,022	96%
Social Policy	200,000	-	8,283,931	11,870,997	4,000.00	482,763.07	200,000	8,770,694	(8,083,931)	4042%
C4D	2,200,000	150,000	-	0	27,827.63	0.00	2,000,000	177,996	2,050,000	93%
Total	**25,100,000**	**2,420,784**	**16,585,755**	**27,556,787**	**2,234,037**	**7,576,661**	**20,150,000**	**28,133,602**	**6,093,460**	**(39)**

Source: Extract from 2021 Zambia HAC annual report[17]

[17] The figures in Table 1 are originated from VISION and Insight. At the time of deriving the information from these two sources, migration of data from 2021 to 2022 had not yet completed in the system. This explains the discrepancy of figures in Table 1 and 2 below on carry-over funds for the nutrition sector as well as the figures in Table 1 and 3 on resources received in 2021.

Table 2: Funding available (received + carry over) by donor and funding type

Donor Name/Type of funding	Programme Budget Allotment reference	Overall Amount*
I. Humanitarian funds received in 2021		
a) Thematic Humanitarian Funds		
See details in Table 3	SM/18/9910	303,346
b) Non-Thematic Humanitarian Funds		
Nil	Nil	nil
c) Pooled Funding **(i) CERF Grants** **(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.		
Nil	Nil	Nil
d) Other types of humanitarian funds		
Example: In-kind assistance (include both GRANTs for supplies & cash) Norway	Nil	Nil
Total humanitarian funds received in 2021 (a+b+c+d)		303,346
II. Carry-over of humanitarian funds available in 2021		
e) Carry over Thematic Humanitarian Funds		
Thematic Humanitarian Funds	SM/18/9910	5,800.8
f) Carry-over of non-Thematic Humanitarian Funds		
ECHO	SM/20/0020	542,589.86
Total carry-over non-Thematic Humanitarian Funds		
Total carry-over humanitarian funds (e + f)		542,589.86
III. Other sources		
UNFPA - USA	SC170758	2,679,730.47
Global - Nutrition Thematic Fund	SC189903	135,676.73
Total other resources		**2, 815, 407.20**

Source: FI Financial Reporting Cube (as per guidelines)

Table 3: Thematic Humanitarian contributions received in 2021

Thematic Humanitarian Contributions Received in 2021 (in USD): Donor	Grant Number[18]	Programmable Amount (in USD)	Total Contribution Amount (in USD)
Germany	SM/18/9910/ 0956	303,346	303,346
Total			303,346

Source: FI Financial Reporting Cube (as per guidelines)

[18] International Aid Transparency Initiative (IATI) requires all grants to be listed in reporting. http://iatistandard.org/

K. FUTURE WORKPLAN

To sustain the gains achieved in 2021 and further address the critical nutrition issues in Zambia, UNICEF plans to support the GRZ in the following key interventions under GRZ-UNICEF Nutrition Programme in 2022:

1. Service delivery in the 17 districts and maintain the required focus on the programme from a systems building and policy perspective.
2. Procurement and provision of supplies including supporting last mile delivery.
3. Strengthening capacities of service providers including health workers and community volunteers.
4. Provide technical and financial support in the finalisation of national IMAM guidelines.
5. Service delivery including provision of nutrition services through implementation of IMAM and IYCF in eight districts in Luapula province benefiting children under five years of age.
6. Supporting and sustaining gains of IMAM scale up in the 58 drought-affected districts and ensure health systems strengthening.

Thematic funds will be used to supplement the estimated nutrition budget for 2022, which include service delivery, capacity building, technical assistance, programme monitoring and management.

ANNEXES

Annex a: Human Interest Stories and Links

Annex b: Donor Statement (As of 31 December 2021

Annex c: Link to online Donor Report Feedback Form

Annex a: Donor Statement (As of 31 December 2021)

UNITED NATIONS CHILDREN'S FUND (UNICEF)

OTHER RESOURCES CONTRIBUTION RECEIVED FROM: GLOBAL - THEMATIC HUMANITARIAN RESPONSE

DONOR STATEMENT BY ACTIVITY (UNCERTIFIED) FROM 01 JANUARY 2018 TO 31 DECEMBER 2021 IN US DOLLARS

Status of Contribution

External Reference:	THEMATIC HUMANITARIAN
Description:	2018-2021 Humanitarian ActionThematic Pool
Contribution Reference:	SM189910
Effective Date:	01.01.2018
Expiry Date:	31.12.2022
Recipient Office(s):	EAPR Regional Office, ECAR Regional Office, ESAR Regional Office, LACR Regional Office, MENAR Regional Office, SAR Regional Office, WCAR Regional Office, Afghanistan, Albania, Algeria, Analysis Planning & Monitoring, Angola, Armenia, Azerbaijan, Bangladesh, Barbados, Belarus, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Bulgaria, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, China, Colombia, Comoros, Congo, Croatia, Cuba, DP Republic of Korea, Democratic Republic of Congo, Division of Human Resources, Djibouti, Dominican Republic, Ecuador, Egypt, El Salvador, Eritrea, Eswatini, Ethiopia, Evaluation Office, Fiji (Pacific Islands), Gambia, Georgia, Ghana, Global Communication &Advocacy, Greece, Guatemala, Guinea, Guinea Bissau, Guyana, Haiti, Honduras, India, Indonesia, Info & Comm Technology Div, Iran, Iraq, Jordan, Kenya, Kosovo (UN SC resolution 1244), Lao People's Dem Rep., Lebanon, Lesotho, Libya, Madagascar, Malawi, Malaysia, Maldives, Mali, Mauritania, Mexico, Morocco, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, North Macedonia, Office of Emergency Prog., Office of Research Italy, Oman, Pakistan, Palestine State of, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Programme Division, Public Partnerships Division, Rep of Uzbekistan, Republic of Cameroon, Republic of Kyrgyzstan, Republic of Montenegro, Republic of Mozambique, Rwanda, Sao Tome & Principe, Saudi Arabia, Serbia, Sierra Leone, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Syria, Tajikistan, Timor-Leste, Togo, Tunisia, Turkey, Turkmenistan, Uganda, Ukraine, United Rep. of Tanzania, Uruguay, Venezuela, Vietnam, Yemen, Zambia, Zimbabwe
Agreement Currency:	Various

Funds Received:	USD	0.00
Refunds:	USD	0.00

Summary of Expenditures (USD)

Description	Cumulative Expenditure
Programmable Expenditure:	358,002.14
Indirect support cost 5.524090%	19,776.36
Total:	**377,778.50**
Funds Received in USD:	0.00
Unspent Balance:	**(377,778.50)**

Summary of Expenditures by Recipient Office (USD)

Country/Regional Office	Incurred Expense 2018-2020	Incurred Expense 2021	Cash Advances and Prepayments	Cumulative Expenditure	Commitments*
Zambia	192,644.30	100,568.16	84,566.03	377,778.50	683.20
Total	**192,644.30**	**100,568.16**	**84,566.03**	**377,778.50**	**683.20**

* "Commitments" include undelivered purchase orders, payment commitments for implementing partners and travel advances approved but not yet paid. The amounts shown in this column represent the status and value of the commitment as at the date the report is produced. As goods are received and commitments in respect of implementing partners and travel advances are paid these amounts will be added to "incurred expense".

UNITED NATIONS CHILDREN'S FUND (UNICEF)

OTHER RESOURCES CONTRIBUTION RECEIVED FROM: GLOBAL - THEMATIC HUMANITARIAN RESPONSE

DONOR STATEMENT BY ACTIVITY (UNCERTIFIED) FROM 01 JANUARY 2018 TO 31 DECEMBER 2021 IN US DOLLARS

Details of Expenditures by Activity - Office: **Zambia**

Outcome / Output / Activity Description	Incurred Expense 2018-2020	Incurred Expense 2021	Cash Advances and Prepayments	Cumulative Expenditure	Commitments*
Outcome 300 03 WASH	**9,043.84**	**30,956.16**	**0.00**	**40,000.00**	**0.00**
Output 001 03-01 COMMUNITY WATER SUPPLY	**9,043.84**	**30,956.16**	**0.00**	**40,000.00**	**0.00**
Activity 013 PROVISION OF SAFE WATER SUPPLY TO EMERGENCY AFFECTED POPULATIONS	**9,043.84**	**30,956.16**	**0.00**	**40,000.00**	**0.00**
Contractual Services	9,043.84	30,956.16	0.00	40,000.00	0.00
Outcome 400 04 NUTRITION	**12,893.45**	**61,699.52**	**80,139.08**	**154,732.05**	**683.20**
Output 002 04-02 MANAGEMENT OF ACUTE MALNUTRITION	**12,893.45**	**28,564.08**	**80,139.08**	**121,596.61**	**0.00**
Activity 023 IMAM PROGRAMME MONITORING AND NUTRTION SURVEYS/SURVEILLANCE	**12,893.45**	**28,564.08**	**0.00**	**41,457.53**	**0.00**
Travel	0.00	706.04	0.00	706.04	0.00
Transfers and Grants to Counterparts	12,893.45	27,858.04	0.00	40,751.49	0.00
Activity 027 CAPACITIY BUILDING FOR IMAM SERVICES	**0.00**	**0.00**	**80,139.08**	**80,139.08**	**0.00**
Transfers and Grants to Counterparts	0.00	0.00	80,139.08	80,139.08	0.00
Output 003 04-03 NUTRITION PROGRAM SUPPORT	**0.00**	**33,135.44**	**0.00**	**33,135.44**	**683.20**
Activity 001 STAFF COSTS	**0.00**	**33,135.44**	**0.00**	**33,135.44**	**683.20**
Staff and Other Personnel Costs	0.00	31,907.93	0.00	31,907.93	683.20
General Operating + Other Direct Costs	0.00	1,227.51	0.00	1,227.51	0.00
Outcome 500 05 EDUCATION	**47,832.96**	**675.00**	**0.00**	**48,507.96**	**0.00**
Output 003 05-03 EDUCATION FOR OUT OF SCHOOL	**47,832.96**	**675.00**	**0.00**	**48,507.96**	**0.00**
Activity 018 CAREER CLUBS	**47,832.96**	**0.00**	**0.00**	**47,832.96**	**0.00**
Supplies and Commodities	47,832.96	0.00	0.00	47,832.96	0.00
Activity 023 COVID -19 RESPONSE- ALTERNATIVE LEARNING INCLUDING REMOTE TEACHER SUPPORT	**0.00**	**675.00**	**0.00**	**675.00**	**0.00**
Supplies and Commodities	0.00	675.00	0.00	675.00	0.00
Outcome 600 06 CHILD PROTECTION	**73,026.19**	**1,972.83**	**0.00**	**74,999.02**	**0.00**
Output 001 06-01 CHILD PROTECTION SYSTEM STRENGTHEN	**54,999.96**	**1,972.83**	**0.00**	**56,972.79**	**0.00**
Activity 059 CHILD PROTECTION EMERGENCY RESPONSE PLANNING AND IMPLEMENTATION (CASE MANAGEMENT	**54,999.96**	**0.00**	**0.00**	**54,999.96**	**0.00**
Travel	(6,251.40)	0.00	0.00	(6,251.40)	0.00
Transfers and Grants to Counterparts	61,251.36	0.00	0.00	61,251.36	0.00
Activity 062 SUPPORT GOVERNMENT TO OVERSEE CHILD PROTECTION EMERGENCY RESPONSE PLANNING AND IM	**0.00**	**1,972.83**	**0.00**	**1,972.83**	**0.00**
Transfers and Grants to Counterparts	0.00	1,972.83	0.00	1,972.83	0.00
Output 004 06-04 CHILD PROTECTION PROGRAM SUPPORT	**18,026.23**	**0.00**	**0.00**	**18,026.23**	**0.00**
Activity 001 STAFF COSTS	**18,026.23**	**0.00**	**0.00**	**18,026.23**	**0.00**
Staff and Other Personnel Costs	13,674.93	0.00	0.00	13,674.93	0.00
Transfers and Grants to Counterparts	3,316.87	0.00	0.00	3,316.87	0.00
General Operating + Other Direct Costs	1,034.43	0.00	0.00	1,034.43	0.00
Outcome 880 PROGRAMME EFFECTIVENESS OUTCOME	**39,763.11**	**0.00**	**0.00**	**39,763.11**	**0.00**
Output 008 08-06 EMERGENCY	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Output 009 08-07 DEPUTY REPS OFFICE	**39,763.11**	**0.00**	**0.00**	**39,763.11**	**0.00**
Activity 001 PROGRAMME COORDINATION	**37,643.00**	**0.00**	**0.00**	**37,643.00**	**0.00**
General Operating + Other Direct Costs	37,643.00	0.00	0.00	37,643.00	0.00
Activity 003 SUPPORT BRUSSELS OFFICE ON EU ENGAGEMENT	**2,120.11**	**0.00**	**0.00**	**2,120.11**	**0.00**
General Operating + Other Direct Costs	2,120.11	0.00	0.00	2,120.11	0.00
Total Programmable Cost	**182,559.55**	**95,303.51**	**80,139.08**	**358,002.14**	**683.20**
Indirect support cost 5.524090%	10,084.75	5,264.65	4,426.95	19,776.36	
Total	**192,644.30**	**100,568.16**	**84,566.03**	**377,778.50**	

Annex-b: Link to online Donor Report Feedback Form

UNICEF Donor Feedback Form