Madagascar

Nutrition

Sectoral-OR+Thematic Report

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1. Acronyms

Acronym Term	Definition
AfDB	*African Development Bank*
C4D	Communication for Development
CCC	Core Commitments for Children
CPD	Country Programme Document
CPAP	Country Programme Action Plan
CSFVA	Comprehensive Food Security and Vulnerability Analysis
DHS	Demographic and Health Survey
ECD	Early Childhood Development
FAO	Food and Agriculture Organization
GDP	Gross Domestic Product
IYCF	Infant and Young Child Feeding
MAM	Moderate Acute Malnutrition
MCHW	Maternal and Child Health Weeks
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
NGO	Non-Governmental Organization
ONN	Office National de Nutrition (National Nutrition Office)
PSI	Population Services International
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SUN	Scaling up Nutrition
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

USI	Universal Salt Iodization
WASH	Water, Sanitation and Hygiene
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

2. Executive Summary

The UNICEF Madagascar Country Programme (CPD) started on 1 March 2015. Aligned with the 2015-2019 UNDAF, the 2015-2019 Country Programme contributes to the attainment of programme objectives for public health in the National Development Plan (NDP) as well as the Agenda 2030, especially Sustainable Development Goal (SDG) target 2.2 on ending malnutrition and addressing the nutritional needs of the most vulnerable.

As Madagascar remains off the map for many donors, UNICEF Madagascar continued to seize every opportunity to raise the visibility and be an advocate for the human rights of Madagascar's approximately 23 million people of whom 91 per cent are severely impoverished (living on les than 2 dollars a day[1]) and over half of whom are children. With the end of the political crisis in 2014, the past couple of years have witnessed some reengagement by donors. Madagascar received significantly increased international attention in 2016, notably through high level visits from international organizations and development partners and the Government's accelerated efforts to "re-enter the concert of nations" notably through its chairmanship of COMESA and chairmanship of the International Organization of the Francophonie (OIF).

However, the funds coming in, mainly through direct budget support, are below pre-crisis levels, rendering the situation difficult for the country, which relies heavily on external aid. This means that most public services are critically underfunded and that UNICEF's unique expertise in ensuring equitable access to quality social services with the limited funds available is in high demand. While UNICEF with its partners have contributed to important achievements toward developing a Nutrition system for women and children that is more equitable, resilient and sustainable, our results for children, women and the most vulnerable communities and Madagascar's progress toward SDG target 2.2 would not have been possible without Flexible Thematic Funding, which helped fill funding gaps for the following activities:

- Advocacy for nutrition through the publication of a nutrition investment case and building public support and awareness of nutrition through the National Nutrition Day and the World Breastfeeding week;
- Training of community workers and health staff in Infant and Young Child Feeding (IYCF) promotion and maternal nutrition;
- Scale up of the home-based fortification of complementary food with micronutrient powder; and

[1] MDG survey 2012–2013

- Support to programme supervision and reporting.

The country office aimed to achieve equity outcomes in Nutrition through advocacy for and support to the implementation of evidence-based, inter- sectorial actions within UNICEF, the Government line ministries and partners. In 2016, UNICEF continued its advocacy for equity and evidence-based policy decisions, working closely with the World Bank, World Health Organisation (WHO), the World Food Programme (WFP) the Food and Agriculture Organisation (FAO) and USAID to generate and share data to shape sound policy and strategy decisions to improve coordination and strengthen the governance of the nutrition sector. UNICEF's approach also aimed to maximize impact, increase resilience and sustainability of actions through enhanced capacity and improved access to quality nutrition services at the downstream level, as well as improved responses to nutritional emergencies. In 2016, the majority of UNICEF's support was directed through local health centres and community nutrition sites to achieve a maximum impact for children by intervening as close to where they live as possible.

In non-humanitarian situations, target regions were selected based on an analysis of the most vulnerable regions, where an inter-sectoral intervention of all four UNICEF sectors of intervention (Education, Health, Wash, Nutrition, Child and Social Protection), as well as other UN agency partners was possible.

As a result, UNICEF helped the Government significantly increase the percentage of children benefitting from nutrition interventions in 2016. Over 97 per cent of children were reached with vitamin A and deworming and nearly one million children were screened for acute malnutrition during two rounds of Mother and Child Health Weeks (MCHW). Support (staff training, provision of therapeutic food and essential medicine) was provided to over 645 facilities for the treatment of severe acute malnutrition. In the southern, drought affected areas eight massive screenings were completed, reaching on average 250,000 children (more than 90 per cent of all children in the area) each time. The scale of this humanitarian action helped to ensure access to treatment to 20,200 children with severe acute malnutrition (SAM).

However the major progress towards the CPD outcome and SDG 2 was mainly at the foundational level. This included planning and advocacy for nutrition, capacity building and scale up of nutrition services, including in the emergency affected areas. UNICEF contributed to reinforced provision of quality nutrition care and the adoption of practices that are favorable to nutrition. At the upstream level, advocacy resulted in an increase of the budget allocated to the National Nutrition Office (ONN) by over 200 per cent (from US$ 1.5 million to 5 million), including significantly increased support to Nutrition from the World Bank and the African Development Bank. At the operational level 71 per cent of health facilities 82 per cent of all community nutrition sites in the 6 target regions for the IYCF are currently offering counseling for IYCF and maternal nutrition.

Overall, with its government partners, UNICEF contributed to important advances toward a Nutrition sector that is more equitable and sustainable in 2016, with stronger capacity to provide quality services to all.

To address the challenge of the sheer scale of malnutrition and stunting in Madagascar, UNICEF will maintain its support at both upstream and operational levels to raise the percentage of babies that are exclusively breastfed, reduce the percentage of children who are stunted and decrease the percentage of low birthweight newborns per our CPD. We will continue to support the MCHW to maintain high coverage of children and mothers covered with Vitamin A supplements and deworming. We will continue to scale up the IYCF interventions in the 6 target regions and will further integrate it with free access of children aged 6 to 23 months to micronutrient powder for improvement of dietary food complements. UNICEF will improve the scale and quality of the nutrition emergency response in the south through the setup of mobile clinics for Severe Acute Malnutrition (SAM) treatment. The Universal Salt Iodisation (USI) programme will receive adequate support, ,ensuring that at least 85 per cent of all table salt in the country has adequate level of iodine for the improved nutrition of all Malagasy by the end of 2017.

3. Strategic Context 2016

Madagascar continued to be marked by political, economic and natural disaster-related challenges in 2016. Cautious optimism on economic development was coupled with a renewed government re-shuffle. Concerns about prevailing high poverty levels and the continuing drought emergency in the South made this another difficult year for the country and a challenging and demanding context for the UNICEF programme.

The reality for Madagascar is that, despite continued progress in certain sectors, the investments made on behalf of women and children, especially the most vulnerable, are not yet sufficient to ensure the long-term realisation of their rights and ensure that Madagascar will make progress with the Sustainable Development Goals (SDGs). The country remains on the lower ranks of many international indices. It currently ranks 154 out of 188 on the Human Development Index[2], 123 out of 133 on the Social Progress Index[3], 141 out of 150 on the World Happiness Report[4], and 166 out of 178 on the Environmental Performance Index[5].

While Madagascar is often characterised by its rich ethnic, cultural and biological diversity, persistent poverty and political instability remain the main barriers for development. In the latest Global Monitoring Report from the World Bank, Madagascar occupies the 1st place with a poverty rate of 81.8 per cent, showing the largest number of poor.[6] It is the only country in the region with a historically declining GDP. According to the World Bank, It is the only country in the region with a historically declining GDP: families are on average 40 per cent poorer than they were in 1960.[7]

Around half of Madagascar's population is under 18 years and almost 16 per cent are under the age of 5.[8] These youth are a cohort, who represents a 'window of opportunity' for embedding positive life-long behaviours in favour of positive social change and environmental protection and resilience, but the challenges facing them are formidable.

In global comparisons, Madagascar ranks 4th in the world for highest rate of chronic malnutrition[9] and 4th in the world with the worst WASH indicators, with 40 per cent of people practicing open defecation. Open defecation, coupled with the lack of safe, clean water and poor hygienic practices, like hand washing with soap, are directly responsible for 90 per cent of cases of diarrhoea and have a significant impact on the alarming rate of chronic

[2] HDI 2015
[3] SPI 2016
[4] WHR 2016
[5] EPI 2014
[6] World Bank, 2016; INSTAT/EPM, 2010
[7] Razafindrakoto, 2013; IRD, 2016
[8] State of the World's Children 2015

malnutrition and mortality among children.[10] This, in turn, contributes to the fact that almost 1.7 million school-age children are out of school and of those children in schools, only 3 out of 10 complete the primary cycle.

Furthermore, the island is exposed to the hazardous effects of climate change. It ranks among the top ten countries most vulnerable to cyclones and with the weakest coping capacities.[11] Among the countries most affected by the impacts of weather-related loss events (storms, floods, heat waves etc.) in 2015, Madagascar ranks 8th.[12] Since 2015, nearly 1.5 million people have been affected by an ongoing drought with 53 per cent of them facing severe food insecurity and in urgent need of assistance by the end of 2016.[13]

The 2015-2019 CPD and CPAP were developed to address this difficult context faced by the children of Madagascar, in light of the Post-2015 Development Agenda and in order to help children realize their full potential as set out in The Convention on the Rights of the Child, free from hunger and want, neglect and abuse. The theory of change underpinning our work is based on the belief that one of the major steps to ending "the malnutrition monster" and addressing the nutritional needs of infants and pregnant and lactating women (SDG target 2.2) in Madagascar is to ensure that women and children (under-five) in the most vulnerable zones have improved and sustainable nutritional status. UNICEF streamlined its Nutrition programming under 1 main outcome area in 2015: *By the end of 2019, child nutrition interventions result in better nutrition outcomes in target regions, to better address the high prevalence of stunting, acute malnutrition and micronutrient deficiencies of children and women in Madagascar.*

(a) Situation of Children and Women related to Nutrition

The scale of the poor nutrition, health, security and poverty situation of Malagasy children and their families poses serious challenges to the achievement of SDG 2, *end hunger, promote food security, improve nutrition and promote sustainable agriculture by 2030*. Nearly half of all Malagasy children under 5 years old (about 2 million children) are chronically malnourished. The country is among the 15 top countries in the world with the largest burden of under–nutrition[14]. Chronic malnutrition in children, impacts their cognitive development, their learning capacities and school performance, and their productivity when they become adults. A UNICEF-supported Nutrition investments case estimates the cost of inaction against malnutrition in Madagascar to be US$ 740 million (7.5 per cent of Madagascar's GDP).

[11] World Risk Index 2016
[12] Global Climate Risk Index 2017
[13] IPC 2016
[14] UNICEF Nutrition Report 2013

High prevalence of stunting (low height for age in children), micronutrient deficiencies and acute malnutrition

Malagasy children have suffered from a shocking prevalence of stunting[15] for the past 25 years. Nearly one out of every two children under 5 in Madagascar suffers from stunting[16]. Stunting is due to poor infant and young child feeding practices (breastfeeding and complementary feeding), recurrent illness associated to poor access to basic health care or to basic sanitation services. In Madagascar, only 43 per cent of infants are exclusively breastfed and 31 per cent of those 6-23 months old receive a diet with acceptable diversity. Research shows that stunting is also due to the intergenerational cycle of growth failure, which is transmitted across generations through the mother. In Madagascar, 22 per cent of infants are born small, which points to poor maternal health and nutritional status. Indeed, 33 per cent of women of child-bearing age are underweight[17] and 30 per cent are stunted[18]. The cycle is accentuated by high rates of teenage pregnancy, as adolescent girls are even more likely to have low-birth-weight.

Malnutrition also results from children lacking the amount of key micronutrients required for proper growth. These deficiencies include:

***Iodine deficiency*—** Iodine is a key micronutrient for linear growth and brain development which mostly occurs in-utero. It is therefore critical to ensure that pregnant women and young children have enough iodine. Madagascar adopted mandatory salt iodization in 1995 as a way to improve the iodine status for the population. After about 5 years of implementation of this strategy, the iodine deficiency situation has improved with the prevalence of goitre decreasing from 45 per cent to 6 per cent and the proposition of household with access to slat with iodine increasing from 0.5 per cent to 75 per cent. However, a UNICEF-supported nationwide survey completed in 2015 indicates that the situation has worsened, with only 24 per cent of households with access to iodised salt. Furthermore, the level of iodine in salt was less than 10 PPM while the recommended level is at least 15 PMM, and the median urinary iodine (the main indicator of iodine deficiency disorders) was 46 micro-grams per litre - far below the recommended level (100 to 300 micrograms per litre). Taken together, these indicators suggest that the Malagasy population is facing a moderate level of iodine deficiency with a significant number of vulnerable new-borns.

Iron deficiency *and anaemia*— Around 3.1 million children suffer from anaemia and 35 per cent of women of childbearing age are anaemic in Madagascar; and

[15]Stunting is associated to poor cognitive development, reduced school performance, lower productivity higher risk of chronic diseases in adulthood.
[16]MDG survey 2013
[17]DHS 2008-2009
[18]CSFVA 2010

Vitamin A deficiency — It is estimated that 72 per cent of children between 6 and 59 months do not receive enough vitamin A in their diets. Since 2006, Madagascar has institutionalized the MCHW, which provides vitamin A twice a year to a large number of children nation-wide, frequently reaching 90 per cent coverage. From an equity perspective, however, the 10 per cent not reached are likely to be among the most vulnerable women and children.

In the face of these challenges, the Malagasy Government, with support from UNICEF and other partners, has reduced the levels of acute malnutrition[19] from 13 per cent in 2003 to 9 per cent in 2013. In 2016, specifically, this collaborative effort resulted in more children being treated and cured of SAM in local health centers, from 61 per cent in 2014 to 82 per cent in 2016, exceeding the national target of 80 per cent for the first time. This change represents an 11 percentage point increase in the cured rate compared to 72 per cent in 2015.

Despite these gains, however, the high stunting rates in Madagascar will certainly continue to present one of the biggest challenges to UNICEF's progress toward CPD outcomes for children and Madagascar's progress toward the Sustainable Development Goals, notably those related to the reduction of child and maternal mortality. And given that the country is frequently exposed to natural disasters – cyclones, floods on the coast and drought in the South – the high prevalence of acute malnutrition recurs with each emergency especially the drought, and often passes the emergency threshold (15 per cent). Reversing the current trend of malnutrition, especially stunting and vulnerability to severe malnutrition in the South, requires actions at both strategic and operational levels.

Upstream level – development of nutrition sensitive policies, strategies and coordination

The implementation of the national nutrition plan has remained limited in 2016. Currently, the ONN with UNICEF support is finalizing the third generation of the national nutrition plan focusing on three main areas namely 1) nutrition specific interventions, 2) nutrition sensitive interventions and 3) governance advocacy and coordination. UNICEF conducted and published a nutrition investment case as an advocacy effort to raise awareness and donor contributions at the donors round table held in Paris in December 2016. UNICEF's leveraging influence and regular exchanges with donor partners, such as the World Bank, the African Development Bank and other partners has contributed to a good momentum for financing nutrition at all levels. However, even if resources are available, some challenges will need to be addressed to ensure a successful and at scale implementation of the National Nutrition Plan.

[19] A child with acute malnutrition is too thin for his or her height. Children affected by acute malnutrition are four to nine times more likely to die than well-nourished children.

Due to the unpredictability of emergencies and seasonal peaks in acute malnutrition, it is necessary to ensure not only that all health centres are fully equipped to routinely treat severely malnourished children, but also that a mechanism is in place to anticipate nutrition crises and provide response in a timely fashion. Furthermore these recurring emergencies tend to divert the focus of the Government and partners from the long term preventive nutrition action to the more immediate curative care, creating an imbalance in the intervention required to tackle chronic malnutrition and sustain adequate nutritional levels.

To sustainably reverse the current trend of undernutrition, the Madagascar Country Office CPAP Output 3.1 seeks a coordinated inter-sectorial action at scale. In line with the main pillars of the new National Nutrition Plan, such inter-sectorial action will have to involve the following sectors a) nutrition, b) agriculture and food security, c) WASH, d) health and e) social protection. Other sectors, such as education, industry and commerce may also contribute to addressing under nutrition, especially chronic undernutrition. Prerequisites are, however, that sectors are made sensitive to nutrition and that both nutrition sensitive and nutrition specific actions are implemented at scale and in a coordinated, sustainable manner.

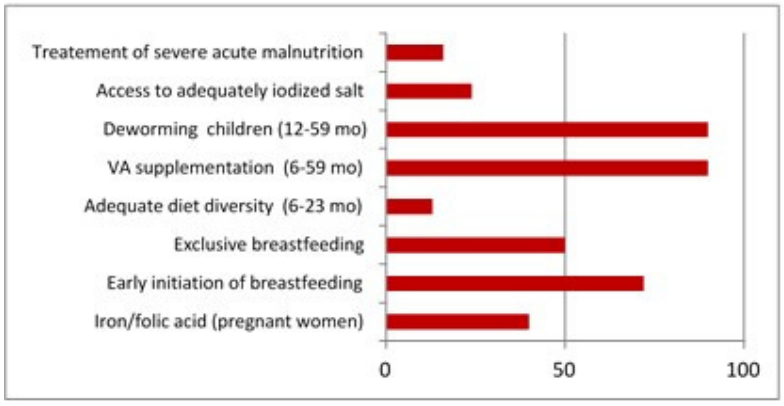
At operational level- ensure high coverage and convergences of quality and equitable nutrition sensitive and nutrition specific services

The 2013 Lancet series on maternal and child nutrition highlighted a number of nutrition specific actions with proven impact on nutrition. However, for Madagascar to reduce undernutrition and achieve SDG 2, theses interventions need 1) to have high coverage (at least 90 per cent) and 2) to be implemented in a coordinated and intersectoral manner with nutrition sensitive actions across WASH, Agriculture, Health, education and social protection. Most of the Lancet-proposed nutrition-specific interventions are currently implemented in Madagascar with support from UNICEF and other partners, but the coverage for most of them is low. As shown in Figure 1, Madagascar has achieved the required coverage (90 per cent) only for Vitamin A supplements and deworming. The outputs in the Nutrition Strategic Outcome Area, therefore, seek to maintain the good coverage of Vitamin A supplementation and deworming and to increase the coverage of the other nutrition specific services. This will be done through strengthened support to the National USI program, MCHW and IYCF counseling, including in the hardest to reach areas.

To improve the scale and quality of infant and young child feeding (IYCF) and maternal nutrition at a regional level, UNICEF will continue to support 1) systems strengthening to deliver community-and facility-based counselling on IYCF and maternal nutrition (MN); 2) scale up home fortification of complementary food with micronutrient powder and 3) implement social mobilization campaigns to shape social norms and improve community engagement to support of IYCF/MN activities.

Additional efforts to address challenges ongoing support to the Ministry of Health (MoH) to hold regular scheduled population-oriented events to provide an increasing number of children and mothers with micronutrients and other nutrition and health services. Moreover, UNICEF's ongoing capacity strengthening in the management of SAM at central and decentralised levels seeks to 1) ensure that every child affected by severe acute malnutrition receives adequate care and ensure that authorities 2) respond in a timely manner to nutritional crises with the objective to prevent excess mortality.

Figure 1 Percentage of women and children benefitting from UNICEF –supported nutrition specific actions with impact on nutrition



(b) Scope

The wide scope of the 2015-2019 UNICEF Country Programme nutrition component is a response to the multiple factors challenging progress toward SDG 2 and the National Development Goal, seeking better nutrition outcomes for all.

In general, the Nutrition Programme partners intersectorally with UNICEF Health, WASH, Communication for Development and Social Policy sectors), and other UN Partners (WHO, WFP, FAO and UNFPA), as well ad Government Ministries to address the nutrition, health, sanitation and hygiene, protection and policy issues affecting all children's rights to health and well-being. Although programming in 2015 was streamlined under one strategic outcome, Nutrition implemented a multi-layered programme strategy, combining support to up-stream policy, legislative frameworks and systems development at the central level, and maintained a focus on decentralized Nutrition sector capacity development, service provision, results monitoring and management at the regional level in 2016.

UNICEF, in partnership with the UN SUN platform (WFP, FAO, WHO and UNFPA), as well as its governmental partners, supports priority actions upstream, midstream and downstream that help increase the scale of interventions at operational level, improve coordination at all levels (central and regional) and maintain advocacy for nutrition. At the strategic level, UNICEF supports the ONN in development of nutrition policies, strategies and plans, in addition to multi-sectorial coordination and evidence generation through the implementation of surveys and studies that generate information for tracking the progress toward the achievement of the goals of the National Nutrition Plan, as well as for supporting advocacy for nutrition.

Most of UNICEF Madagascar's nutrition outputs have nationwide coverage. At the operational level, the UNICEF proposes three main areas of action aiming to 1) improve child feeding practices and maternal nutrition; 2) improve micronutrient nutrition and 3) detect and treat severe acute malnutrition. Output 4 and the IYCF component of output 2 have sub-national coverage, respectively targeting the southern drought affected areas and 6 regions of intervention. These target regions were selected based on an analysis of areas where one or more nutrition-related indicators were not improving and, as a result, not translating to improved nutrition for mothers and children. To extend the scope of interventions and avoid overlapping actions, the selection also took into account the presence of other partners implementing nutrition programmes.

(c) Scale

Generally, UNICEF Madagascar is one of the few organizations that can reach even very remote areas to provide equitable results for children. It is, therefore, best placed to ensure the largest number of the most deprived children have access to Nutrition, Health, WASH and Education interventions. UNICEF's extensive field presence at regional levels allows us to respond to changes in the environment, while complementing government initiatives through UNICEF's own delivery in coordination with national and regional partners to benefit children across the country.

The SAM treatment and the micronutrient component of the UNICEF nutrition programme have national scale while the IYCF component on focuses on 6 priority regions out of all 22 regions in Madagascar.

Activities with national coverage are aimed at benefiting national nutrition and health authorities and the health system as a whole. This covers the total Malagasy population of 25,594,225, including over 4,9 million children under five, 367,000 infants aged less than 6 months, 2,4 million children under 24 months and over 1.02 million pregnant women. The focus population of the 6 priority regions targeted for IYCF interventions is 10.1 million (40 per cent of the total population). The total number of children under five and expected pregnant women (per year) in these regions are respectively 1.9 and 0.41 million.

Indirect beneficiaries include 100 per cent of health and nutrition workers in the six target regions, who participate in training to reinforce competencies relative to treating acute malnutrition and counselling mothers on child feeding and maternal nutrition.

4. Results in Nutrition 2016

UNICEF seeks to aid the realization of the rights of every child, especially the most disadvantaged. The Nutrition Programme, specifically, aims to contribute to sustainable improvements in the nutritional status of the most disadvantaged or vulnerable children under five years old as set out in the CDP 2015-2019 and SDG target 2.2. The following outcome and output level results in 2016, bottleneck analysis and recommended applications of lessons learned are steps towards achieving this goal.

Outcome: By the end of 2019, child nutrition interventions result in better nutrition outcomes in target regions.

Progress towards better nutrition outcomes in target regions is constrained.

The progress against the outcome indicators made in the last year relates mainly to advocacy, related fund leveraging for nutrition and the scale up of preventive and curative nutrition interventions, especially in the most marginalised and drought affected areas of the south.

In 2016, UNICEF maintained support to the nutrition sector at both upstream and operational levels. Although there are no recent data that allow UNICEF to report on progress made toward the target outcomes, results achieved indicate that, while progress towards overall better nutritional outcomes remains constrained, UNICEF has contributed to improvements in the nutrition situation in target regions and nationally.

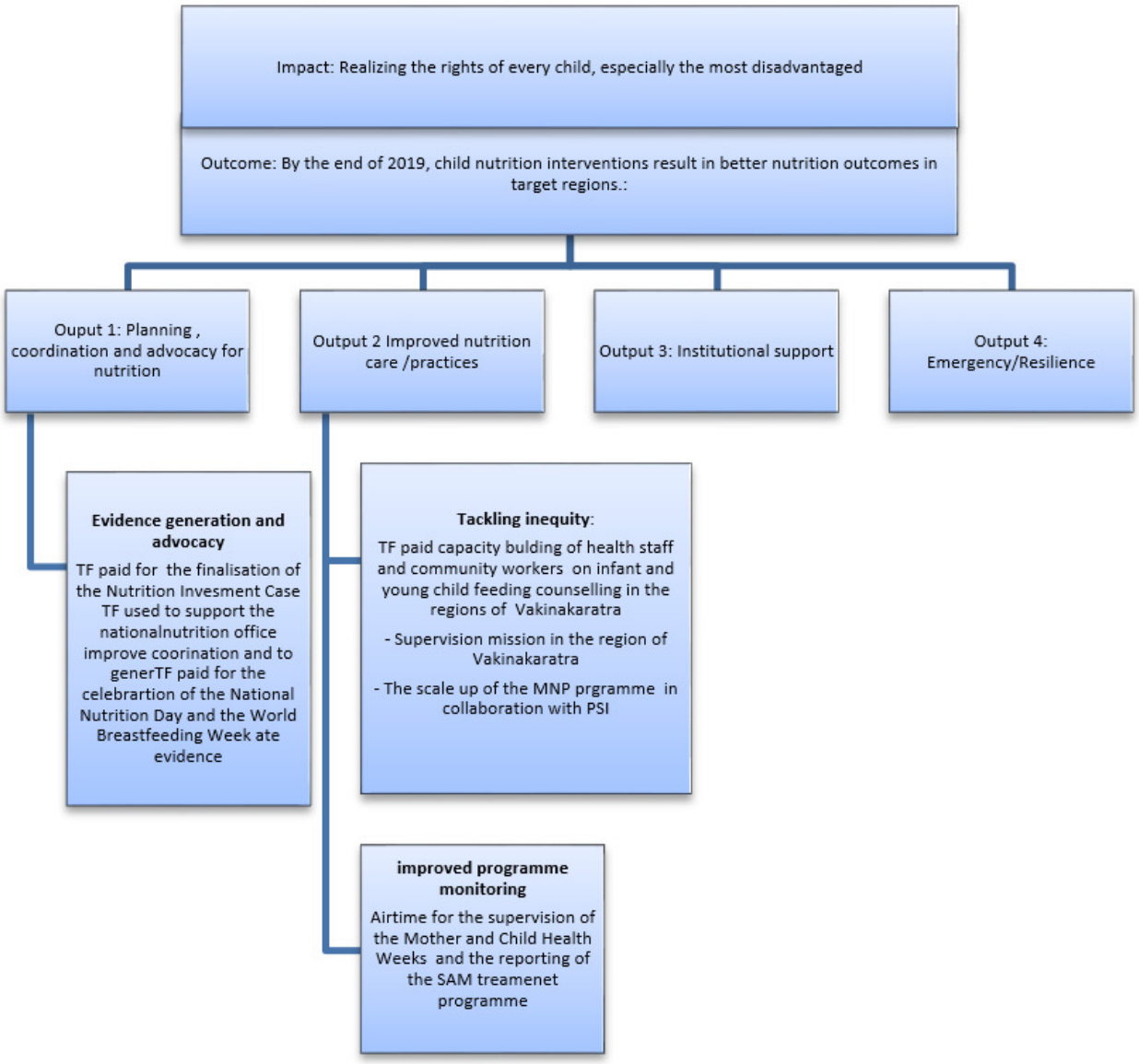
Advocacy effort by UNICEF and other partners (WFP and the World Bank) through the development and publication of a nutrition investment case and a Cost of Hunger report as well as media and communication events have resulted in more attention for nutrition at all levels in 2016. The recent increase of the budget allocated to the ONN, from US$ 1.5 million to 5 million is partly attributable to this advocacy effort. UNICEF also supported the development of a technical note on nutrition - inspired by the nutrition investment case - which was discussed at the donors and investors round table held in Paris in Decembers 2016. Coordination, however, has not been optimal in 2016. While the UNICEF-led coordination of the UN and donor's platform for the SUN movement was successful, there has been little multi-sectorial coordination involving all sectors and platforms since. The development of the new National Nutrition Plan and the update of the national nutrition policy were delayed, beginning only in the last quarter of 2016. However, in response to the publication of concerning results from the national salt iodization survey, a workshop involving all partners led to the development of a plan aimed at ensuring that 85 per cent of all table salt is iodized by end of 2017.

At the operational level, UNICEF maintained its support to interventions aimed at improving IYCF and MN delivered through health facilities and community nutrition sites in the programme's 6 focus regions[20]. In these regions, 71 per cent of all health facilities 82 per cent of all community nutrition sites offered IYCF and MN counseling. Two rounds of MCHW were conducted in 2016. Results of the first round indicate that over 97 per cent of children benefitted from vitamin A supplementation and deworming and 0.97 million children were screened for acute malnutrition nationwide. UNICEF supported the ONN in the provision of staff training, therapeutic food and essential medicine to over 442 facilities for the treatment of children suffering from SAM outside of the emergency context and 195 facilities in the emergency affected areas in the south. Based on reports available at the end of October 2016, a total of 20,200 cases of SAM were admitted for treatment in these facilities. UNICEF also provided equipment and reagents to the central laboratory and two peripheral laboratories for quality control of iodised salt to strengthen the service delivery of the national USI programme. UNICEF in collaboration with the MoH and ONN also maintained and scaled up the response to the El Nino-related nutrition crisis in the southern regions of Madagascar. The number of treatment facilities supported increased from 165 in 2015 to 2,195 in 2016. Eight massive screening were completed in 2016, reaching on average 250,000 children each time. This represents an improvement compared to 2015 when only 3 screening were conducted.

Thematic funds were very important to the scale up and improved equity of these outcome results. They were used to fill funding gaps that would have otherwise resulted in inputs benefitting fewer women and children. Since target populations always include the most vulnerable, especially considering the scale of the Nutrition response to the humanitarian crisis in the South, this would have meant fewer goods and services available and accessible to the most disadvantaged. Figure 2 (on the next page) outlines how Thematic Funds helped strengthen the scale and scope of our strategic interventions in terms of our progress towards the Nutrition Outcome Area.

[20] The programme focus regions are Analamanga, Vakinakaratra, Analanjirofo, Menabe, Atsimo-Andrefana and Anosy.

Figure 2. How Thematic Funds helped UNICEF strengthen its strategic interventions



We assume that financial resources and political commitment will be enough to ensure that the scale, quality and equity of the Nutrition programme has the desired impact. We also assume that quality data will be available and used to inform decision-making, and that partnerships will be built/strengthened and coordinated to maximize the scale and scope of interventions.

Constraint: Persistant and overlapping humanitarian situations, especially in the drought-affected regions in the south, stretched thin already limited budgets and human resources available to support preventive and development type nutrition interventions.

Risk Mitigation: UNICEF recruited six nutrition consultants to support the southern districts in their response to the nutrition emergencies and provided the technical support to scale up innovative approaches to facilitate reporting. UNICEF continued to build local capacity, so that communities are resilient enough to maintain momentum, despite human resource challenges at the central or UNICEF level.

Moreover, in order to meet the challenges of scaling up Nutrition interventions so that these inputs effectively respond to the scale of the situation in Madagascar, leading to better nutrition outcomes for all, UNICEF will maintain advocacy for nutrition mainly through media missions and discussions with the parliamentarians. UNICEF will seize the opportunity of the new nutrition plan to ensure that a minimum package of nutrition-specific interventions is available for women and children nation-wide. As part of its equity mission, UNICEF will place special emphasis on the implementation of this package in the 6 focus regions and will advocate that other partners cover the other regions. Additionally, UNICEF will continue to support the nationwide MCHW and will advocate to the MoH for the adoption of a limited evidence-based package of interventions and for the setup of a formal coordination committee for the MCHW. A special focus will be put on the USI programme to ensure that 85 per cent of the salt produced in the country is adequately iodized by the end of 2017 (in line with the national resolution adopted in July 2016). For children in the southern humanitarian zones, UNICEF will scale up SAM treatment through mobile clinics to ensure that the remaining children, representing the unreached 30 per cent of the SAM caseload, are reached with quality care.

Output 1: **National and regional authorities advocate, for nutrition and plan, budget and coordinate for the scale up of nutrition interventions.**

Progress towards this output is constrained.

As the indicators and baselines were established for the new CPD and CPAP in 2015, there has not yet been sufficient time for any measurable quantitative progress toward Output 1 indicator targets.

On the other hand, the following activity level results contributed to the qualitative progress towards more advocacy, planning and coordination for the scale up of nutrition interventions in 2016:

With regard to advocacy, UNICEF supported the celebration of the National Nutrition Day, which provided an opportunity advocate to decision makers, donors and implementing partners for more attention and support to nutrition and investment in both nutrition specific and nutrition sensitive interventions. Similarly, UNICEF collaborated with the MoH to carry out the celebration of the World Breastfeeding Week, which was an opportunity for the MoH to the raise awareness of mothers about the importance of breastfeeding.

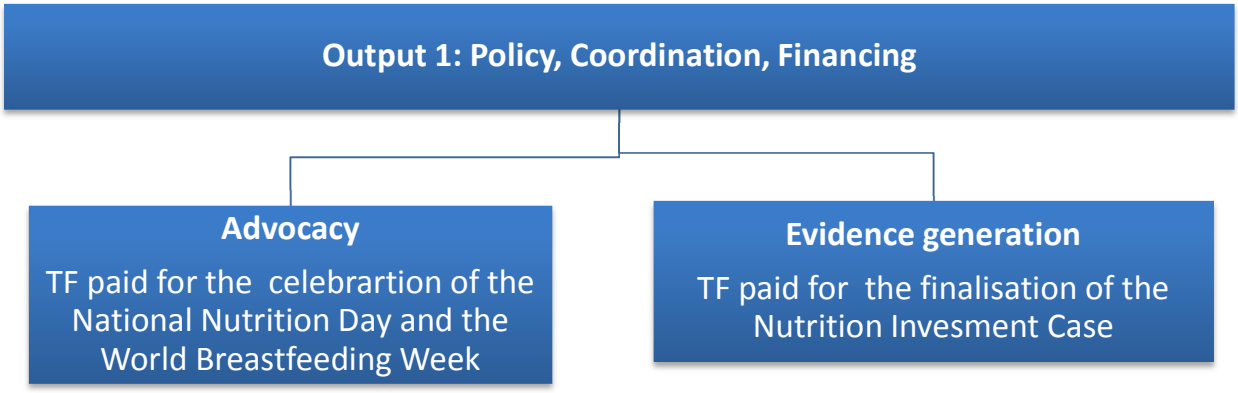
In March 2016, the Secretary General of the United Nations officially presented the nutrition investment case developed in 2015 with UNICEF support to the Prime Minister and the Parliament. Furthermore, the investment case was presented during the donors' round table in Paris in December 2016 and at the summit of nutrition

champions led by the African Development Bank (AfDB) in Ivory Coast in September 2016. These advocacy efforts were successful as 1) the government decided to increase the budget allocated to ONN from US$ 1.5 million to 5 million for the 2017 fiscal year; and 2) the President of Madagascar was nominated by AfDB as one of the African nutrition champions; and 3) the World Bank increased its budget for nutrition through a 4-year programme funded at 25 million dollars per year.

UNICEF also organized several nutrition-focused media and UNICEF National Committees visits in the country in 2016. UNICEF maintained its support to the ONN for the development of the new national nutrition plan, which will be finalised in the first quarter of 2017.

Thematic funds made essential contributions to the increased advocacy and evidence generation for planning and budgeting achieved under this output, as Figure 2 below illustrates.

Figure 2. How Thematic Funds helped UNICEF strengthen its strategic interventions to improve advocacy, strategic planning and coordination (Output 1)



Constraint: Turnover in the management of ONN delayed the development and updates of policy and planning and limited inter-sectorial coordination.

Risk Mitigation: UNICEF continued to coordinate UN agency and other donor members of the SUN platform (WFP, UNFPA, WHO, FAO, USAID and the World Bank). UNICEF also provided a consultant hired to help with the development of the nutrition plan to the ONN.

Output 2: **Reinforced support is provided to children, families and communities through the provision of quality nutrition care and the adoption of practices that are favourable to nutrition.**

Progress towards this output is on-track.

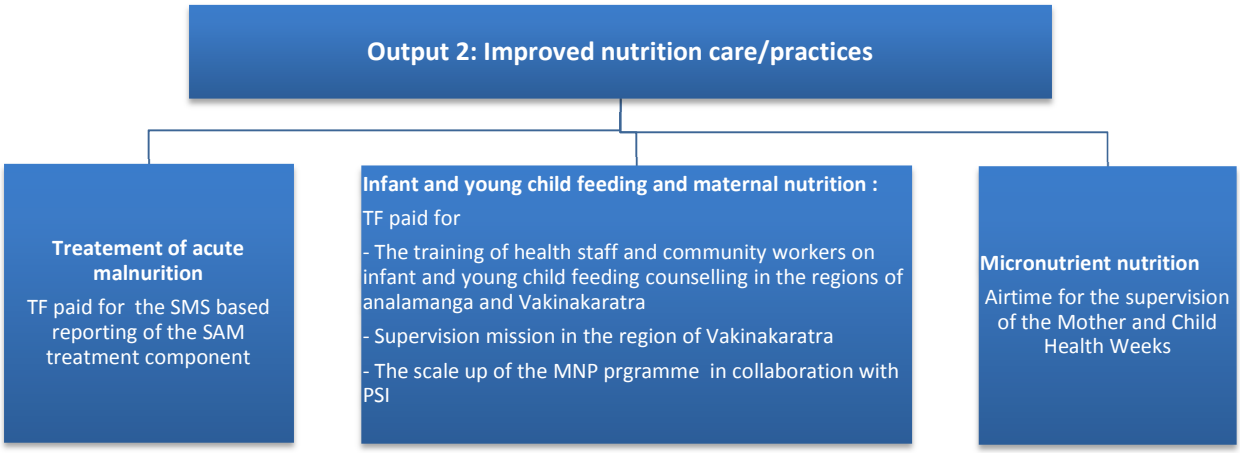
Two rounds of MCHW were held. In the first round 3.8 million children (97.6 per cent of the target population nationwide) received vitamin A supplementation, 3.4 million (98.8 per cent) were dewormed and nearly one million were screened for SAM.[21] The concerning survey results on the iodine status of the population issued in a UNICEF supported led to, a collaborative workshop during which the ONN and its partners developed a plan which aims to ensure that 85 per cent of all table salt is adequately iodized by end of 2017.

In collaboration with the ONN, UNICEF interventions to improve IYCF and MN were delivered through health facilities and in communities in the 6 focus regions of the nutrition programme. In 2016, 109 health staff from 81 health facilities and 1,013 community workers were trained and equipped for facility and community based IYCF counseling. As a result, the proportion of health facility with IYCF counseling capacity increased from 63 per cent in 2015 to 71 per cent in 2016. The proportion of communities (fokontany) with IYCF counseling capacity also increased from 64 per cent to 82 per cent over the same period. Children in a total of 263 communities also gained access to micronutrient powders−through social marketing−to improve the quality of their diet in 2016. In non- emergency areas, UNICEF provided 8,500 boxes of Ready to Use Therapeutic Food (RUTF) and essential drugs to 415 SAM treatment facilities, providing the potential to reach 5,500 SAM case with treatment.

Thematic funds made essential contributions to extending strategic interventions that made gains towards the delivery of quality nutrition preventive and curatives services at a greater scale compared the last year, as Figure 3 below illustrates.

Figure 3. How Thematic Funds helped UNICEF strengthen its strategic interventions to improve the scale and quality of essential nutrition services

[21] The results from the second round of MCHW are not yet complete.



Constraint: Collection and treatment of IYCF data relative to is not systematic

Risk Mitigation: UNICEF advocated to include IYCF indicators in the community-based health information system (C-HIS) and urged the members of the IYCF task force to refer to the C-HIS.

Constraint: Coverage of SAM treatment in the non-emergency areas is overshadowed by the priority of SAM treatment in humanitarian response zones and is insufficient as a result.

Risk Mitigation: UNICEF will revise the national protocol for SAM treatment and will hold a workshop to analyze the bottleneck of the SAM treatment programme and develop a scale up plan.

Risk: The package of the MCHW is subject to frequent changes, with inclusion of interventions for which evidence and effectiveness are questionable. This risks jeopardizing the quality and impact of the other evidence-based-services

Risk Mitigation: UNICEF is working with the MoH to adopt a definitive standard package for the MCHW, which will only include evidence-based nutrition and health services.

Output 3: The capacities at national and regional level are increased to ensure large scale access of beneficiaries to nutrition interventions.

Progress towards this output is constrained.

There was little progress this year in capacity building at national and regional levels that would lead to larger scale access to nutrition interventions. The discussion on the inclusion of nutrition in the pre-services training curricula did not progress and the attempt to integrate nutrition supplies in the health supply chain through SALAMA[22] was inconclusive as the major bottleneck of the within district transportation remained unresolved. As a result, UNICEF continued to use a parallel system for the dispatch of nutrition supplies. Regarding Early Child Development (ECD) targets, UNICEFs Nutrition and Education sections led the pilot of a comprehensive EDC intervention in one community. In 2016, Infrastructures were built and materials development began. With regards to support at regional level, UNICEF supported the establishment of multi-sectorial coordination units in the regional nutrition office of Vakinakaratra as well as in all 7 districts offices of the region.

Thematic funds have were not use for this output in 2016.

Constraint: Efforts remained prioritised on the response to the crisis in the south, which stretched thin already limited human resources, contributing to slower than expected progress in non-humanitarian response regions.

Risk Mitigation: The nutrition staff at central level provided support either remotely or through field missions to non-humanitarian response regions.

Output 4: **Capacities are available at national and regional levels for a timely and efficient response to nutritional crises and to maintain a minimum delivery of nutrition services in case of natural disasters.**

This target was met for 2016.

In early 2016, UNICEF maintained its support to the drought-related crisis response in southern Madagascar through the coordination of the nutrition cluster and support to the MOH for the treatment of SAM. In addition to leadership of the cluster at the national level, UNICEF partnered with decentralized authorities to establish nutrition sub-clusters in six of the eight affected districts through the coordination of six UNICEF supported nutrition field level consultants. At central level, nine Cluster coordination meetings were led by UNICEF. On average, six coordination meetings were held at district level. With regards to the treatment of SAM, UNCEF supported eight massive screenings of nearly all children aged 6 -59 months in the affected districts and provided over 12,000 boxes of RUTF to 195 treatment facilities. A total of 14,700 cases of SAM were admitted for

[22] SALAMA is parastatal agency in charge of the health supply chain

treatment. In UNICEF supported health centers and facilities. Of the children admitted for treatment, 71 per cent were cured, 12 per cent did not finish treatment and .05 per cent died.

Constraint: Fewer children were cured of SAM due to a high proportion of patients not completing the full treatment at the beginning of 2016.

Risk Mitigation: UNICEF has completed a study to better understand the reasons why some cases are not completing the treatment and this has helped develop mitigation measures such as improving the communication between the health staff and caretakers.

Constraint: Limited number of admissions in the inpatient treatment facilities due to caretakers not willing to stay in hospital

Risk Mitigation: UNICEF has provided the district staff with funds to covers the meals of the caretakers of cases who required in-patient care.

Constraint: Abusive use of some of the nutritional products (plump sup for prevention) that has the potential to compromise the SAM treatment programme.

Risk Mitigation: A special cluster meeting was called to discuss the use of the various products and has led to a recommendation made to all partners to immediately stop any inappropriate use of the products and to stick to the national treatment protocol.

Results Assessment Framework

The following table summarizes the indicators in the outcome area and the results achieved in 2016. Baseline and target indicators provide a reference to analyse progress.

Outcome: **By the end of 2019, child nutrition interventions result in better nutrition outcomes in target regions.**			
Outcome indicators	**Baseline (% and/or #)**	**Target (% and/or #)**	**Progress (% and/or #)**
% of children who are exclusively breastfed for the first six months	43% (2013)	60%	43% (2013)
% of children who are stunted	girls: 44.5%; boys: 50.2% (2013)	girls: 34%; boys: 40%	girls: 44.5%; boys: 50.2% (2013)
% of children aged 6-23 months receiving the minimum acceptable diet	13% (2010)	30%	13% (2010)
% of children with severe acute malnutrition admitted to a treatment facility who are cured	61% (2014)	80%	71% (2014)
% of newborns with a low birth weight (under 2500g)	11% (2013)	5%	11% (2013)

Output 1 – National and regional authorities advocate, for nutrition and plan, budget and coordinate for the scale up of nutrition interventions.			
Output indicators	**Baseline (% and/or #)**	**Target (% and/or #)**	**Progress (% and/or #)**
% increase in budget allocated to nutrition	0.28% (2015)	4%	0.28 However the ONN budget has tripled (2016)
Number of updates of the Common Result Framework of the national nutrition plan	0 (2015)	20	2 (2016)
Existence of an updated and budgeted multi-sectorial nutrition plan which includes component on early childhood	0 (2015)	1	0 (2016)
Output 2 – Reinforced support is provided to children, families and communities through the provision of quality nutrition care and the adoption of practices that are favourable to nutrition.			
Output indicators	**Baseline (% and/or #)**	**Target (% and/or #)**	**Progress (% and/or #)**
Proportion of severely undernourished children reached with treatment	12% (2014)	25%	16% (2016)
Proportion of children aged 6-59 months who received two doses of vitamin A	96% (2014)	98%	97.6% (2016)
Proportion of children aged 12 to 59 months who are dewormed at least twice	96% (2014)	98%	98.8% (2016)
Proportion of communities (villages) in the programme focus regions with functional community nutrition and ECD sites	26% (2014)	80%	82.5% (2016)
Output 3 -The capacities at national and regional level are increased to ensure large scale access of beneficiaries to nutrition interventions.			
Output indicators	**Baseline (% and/or #)**	**Target (% and/or #)**	**Progress (% and/or #)**
Existence of a nutrition supply plan integrated to the health supply plan	0 (2015)	1	0 (2016)
Number of pre-service training curricula of the health services providers and teachers that are revised to include nutrition	0 (2015)	3	0 (2016)
Number of target regions that have regional multi-sectorial nutrition plan which include ECD component	0 (2015)	6	1 (2016)
Proportion of health facilities in the 6 focus region that have the capacity (trained staff and equipment) for the promotion of infant and young child feeding , maternal nutrition and ECD	25% (2014)	100%	71% (2016)
Proportion of health/community workers in target regions who have capacity (trained in IYCF) to provide IYCF counseling services to communities	57.3% (2014)	75.2%	82% (2016)
Proportion of Health workers (clinicians) who have been trained on the clinical management of SAM cases and medical complications	36.6 (2014)	61.8% (nationally)	53 (2016)
Output 4 - Capacities are available at national and regional levels for a timely and efficient response to nutritional crises and to maintain a minimum delivery of nutrition services in case of natural disasters.			

Output indicators	Baseline (% and/or #)	Target (% and/or #)	Progress (% and/or #)
Proportion of confirmed nutritional crises that have received a CCC-based response	100% (2014)	100%	100% (2016)
Proportion of nutrition crisis that received a response within two week after confirmation	0 (2014)	80%	100% (2016)

5. Financial Analysis

Table 1: Planned Budget for Outcome Area 4: Nutrition

Outcome Area 4: Nutrition

Madagascar

Planned and Funded for the Country Programme 2016 (in US Dollar)

Outputs	Funding type[23]	Planned Budget [24]
04-06 Nutrition # General	RR	566,000
	ORR	773,400
Unknown	RR	684,000
	ORR	1,328,400
Total Budget		**3,351,800**

UNICEF's own Regular Resources funding for the programme represents around 37 % per cent of the total budget, illustrating the fact that the programme continues to rely on Other Resources (OR) to support the implementation of the nutrition programme It is important to highlight the critical role that Thematic funding plays in the nutrition programme in Madagascar especially given the relatively low allocation of Regular Resources to the programme compared to other UNICEF programme. Thematic funding gives the Nutrition programme one of its only sources with which to fill significant funding gaps, to balance funding allocations across the OR range of supported activities.

[23] RR – Regular Resources; ORR – Other Resources - Regular

[24] Planned budget for ORR *(and ORE, if applicable)* does not include estimated recovery cost. Figures come directly from official annual work plan for 2013-2014 signed with MNE.

Table 2: Country-level thematic contributions to outcome area received **in 2016**

Outcome Area 4: Nutrition

Thematic Contributions Received for Outcome Area 4 by UNICEF Madagascar in 2016 (in US Dollars)

Donors	Contribution Amount	Programmable Amount
Belgian Committee for UNICEF		
Netherlands Committee for UNICEF	137,696	126,932
Total	137,696	126,932

The flexibility of thematic funds has been crucial in targeting areas for which it has been difficult to fundraise, and have thus allowed for the CO to fill gaps. Not having Thematic Funds limited to a single year is also extremely helpful as it allows for flexibility and removes the stress of actions having to fit within the calendar year.

Table 3: Expenditure in the Outcome Area

Outcome Area 4: Nutrition

Madagascar

2016 Expenditures by Key-Results Areas (in US Dollars)

Organizational Targets	Expenditure Amount*			
	Other Resources - Emergency	Other Resources - Regular	Regular Resources	Grand Total
04-01 Infant and Young child feeding	-1,145	173,156	123,585	295,596
04-02 Micronutrients	-5,714	1,105,198	284,080	1,383,564
04-04 Community-based management of acute malnutrition	656,810	344,260	467,763	1,468,833
04-05 Nutrition and emergencies	595,580	-2,109	56,003	649,474
04-06 Nutrition # General	-2,614	284,266	597,564	879,216
Grant total	1,242,917	1,904,772	1,528,994	4,676,682

*Expenditure figures provided do not include recovery cost, and are indicative figures obtained from UNICEF Performance Management System.

The table below shows a more specific breakdown of actual funds used by specific intervention code.

Table 4: Thematic Expenses by Programme Area

Row Labels	Expense
Other Resources - Regular	144,349
04-01 Infant and young child feeding	45,707
04-02 Micronutrients	61,011
04-04 Community-based management of acute malnutrition	1,329
04-05 Nutrition and emergencies	231
04-06 Nutrition # General	36,071
Grand Total	144,349

Table 5: Expenses by Specific Intervention Codes

Row label	**Expense**
04-01-01 Infant and young child feeding implementation (including BFHI)	256,374
04-01-04 Growth monitoring and promotion	3,289
04-02-01 Vitamin A supplementation	68,846
04-02-02 Elimination of iodine deficiency	203,758
04-02-05 Micronutrient supplementation for children	1,020,001
04-04-01 Treatment of Severe Acute Malnutrition	718,372
04-04-02 Treatment of Moderate Acute Malnutrition	656,813
04-05-02 Nutrition # emergency preparedness and response	636,606
04-06-01 Nutrition # General	592,674
08-01-01 Country programme process	1,321
08-01-06 Planning # General	39,707
08-02-08 Monitoring # General	2,332
08-03-01 Cross-sectoral Communication for Development	95,520
08-03-02 Communication for Development at sub-national level	77,367
08-04-01 Parenting programmes / parenting education and support	43,242
08-09-06 Other # non-classifiable cross-sectoral activities	233,203
08-09-07 Public Advocacy	6,133
08-09-08 Engagement through media and campaigns	4,951
08-09-09 Digital outreach	6,056
08-09-10 Brand building and visibility	15,928
08-09-11 Emergency preparedness and response (General)	26,072
10-07-12 Management and Operations support at CO	4,851
1021 Micronutrient supplementation	3,592
1161 Nutrition surveillance	171
12-02-01 Private sector fundraising (Offset budget)	5,906
7921 Operations # financial and administration	-46,402
Grand total	**4,676,682**

*Total Utilized figures exclude recovery cost and are indicative figures obtained from UNICEF Performance Management System.

6. Future Workplan

With regard to planning, coordination and advocacy UNICEF will 1) support the ONN to complete the revision of the nutrition policy and the development of the nutrition plan; 2) maintain its advocacy effort, especially with parliamentarians, to ensure enforcement of nutrition-related legislation such as the code of commercialization of breastmilk substitutes and mandatory salt iodization; and 3) support ONN to institutionalize multi-sectorial coordination around the monitoring framework of the new nutrition plan.

In relation to service delivery, UNICEF will support the inclusion of the MNP in the MCHW package, especially for regions with a high prevalence of chronic malnutrition. UNICEF will also aim to help the MoH and ONN reach 100 per cent of communities and health facilities in the 6 focus regions with IYCF counselling. In order to improve programme monitoring, UNICEF will support the training of the district senior health staff in LQAS surveys as well as their implementation at districts level so as to improve the monitoring of nutrition interventions. In close collaboration with the ONN, a scale up plan for SAM treatment will be developed and implemented. In addition, UNICEF will place a special focus on support to the USI programme to ensure that 85 per cent of the salt produced in the country is adequately iodized by end of next year.

In 2017, UNICEF will complete the hiring of the regional level staff for three focus regions (Atsimo Andrefana, Vakinakaratra and Androy). These staff members will support the establishment of regional coordination units and the setup of regional task forces for ICYF.

With regard to emergencies and resilience, UNICEF will maintain and even strengthen its support to the crisis response. Regular massive screening will be maintained and support will be provided to mothers for routine screening of their own children. Coordination at central and district level will be improved. Treatment will be scaled up through the setup of mobile clinics in order to reach the remaining 30 per cent of cases still not reached due to long distance they have to travel to get to treatment facilities. Concerned national actors will receive technical support to carry out Nutrition SMART[25] surveys in order to provide solid evidence on the malnutrition and mortality situations.

[25] Standardized Monitoring and Assessment of Relief and Transition

Planned Budget for 2017

	Necessary funds	Available			Gap
	Total	RR	OR	Total	Total
National and regional authorities advocate, for nutrition and plan, budget and coordinate for the scale up of nutrition interventions.	357,400	177,306	108,209	285,515	71,885
Reinforced support is provided to children, families and communities through the provision of quality nutrition care and the adoption of practices that are favourable to nutrition.	1,376,600	442,000	588,763	1,030,763	345,837
The capacities at national and regional level are increased to ensure large scale access of beneficiaries to nutrition interventions.	294,000	120,758	21,000	141,758	152,242
Capacities are available at national and regional levels for a timely and efficient response to nutritional crises and to maintain a minimum delivery of nutrition services in case of natural disasters	341,800	107,593	3,802,303	3,909,896	(3,568,096)

7. Expression of Thanks

UNICEF Madagascar would like to express sincere appreciation to all its donors for their essential and highly valued support toward the Nutrition programme. Generous thematic contributions have allowed UNICEF to be flexible and provide comprehensive programmatic assistance to the Nutrition sector in Madagascar, benefitting hundreds of thousands of children. This funding has also helped mitigate as far as possible the lingering impact of the political crisis, thereby ensuring progress towards the fulfilment of child rights, despite the challenging political situation.

UNICEF also wishes to thank its Nutrition programme partners for their effective collaboration as part of the programme, and to all the National Committees and the Government of Madagascar without whom UNICEF's work would not have been achieved.

8. Annexes

Human Interest Story

Mobile Nutrition Teams Key to Reaching the Unreached in Southern Madagascar

Amboro, Ambovombe District, Androy Region, March 2017: It is two in the afternoon and the heat is at its height, burning the scarce crops and sandy roads. Not many cattle can be seen around as many of them have been sold by habitants to buy food.

Ambovombe District has been blighted by severe drought since 2015. For the population, mostly rural and dependent upon rain-fed agriculture, this is the third consecutive year they have seen little rain. What remains to be eaten is a bit of cassava and fruits from cactus. If the rain finally comes, people hope to harvest some maize, sweet potatoes and cassava.

Mobile Nutrition Teams Provide Some Hope

Despite the late arrival of the nutrition team in Amboro, due to a mechanical problem encountered on the dilapidated road, a dozen of mothers and their children are patiently waiting in the shadow of a tree.

“Even if we are five hours late, it was not possible for us *not* to come,” says Vony, one of the three members of the mobile nutrition team. “Many children are severely malnourished and they need to receive treatment,” she adds. “Their lives depend on us”.

The closest health centre is three hours’ walking distance, and the team brings access to nutrition services to thousands of children at risk of malnutrition.

Soon after their arrival, the team starts screening all children under five years old using a tape to measure their middle-upper arm circumference. If the color band reaches only the red zone (less than 11.5 cm), the child is severely malnourished and admitted in the therapeutic feeding program. The team also checks weight and height of children to further assess nutritional condition; children with medical complications are referred to the closest health centre for further investigation and care.

In Amboro, Nandrianina from the mobile nutrition team screens a child for malnutrition using a color-coded measuring tape.

When the measuring tape reaches the yellow zone (between 11.5 and 12.5 cm), the child is moderately malnourished and admitted to the supplementary feeding site supported by the World Food Programme (WFP) and located next to the tree where mothers are waiting. “Today, out of the twelve children screened, we have identified five new moderately malnourished children,” says Nandrianina, one of the other team members.

Mobile Treatment of Malnutrition

Ravo, 30, walked the short distance to the mobile nutrition team with her eight month-old child Lamiaze and three siblings; her two older children stayed at home. One week before, Lamiaze had been assessed and diagnosed with severe acute malnutrition. This is the second time her mother has brought him back for follow-up treatment.

"He had a cough and diarrhoea," Ravo explains. "I bring him here and they give him Ready-to-Use Therapeutic Food and antibiotics. They also check his weight and give me advice."

For Vony, this is an all too familiar story. Acknowledging the dozen women and children gathered around her, she sighs. "In the two first weeks of operation, we have covered nine remote locations and admitted 31 severely malnourished children in the program. Another 180 severe moderate cases were referred to the supplementary feeding programme,” she explains. “We are expecting to see many more if the situation doesn’t improve.”

Lamiaze’s condition is rapidly improving and Ravo has faith in the treatment he is receiving. "Previously, we didn't have access to modern medicine," she laments. "Now that he is receiving this treatment, we have seen great improvement in his health."

Lamiaze and his mother at his second visit for the treatment of severe acute malnutrition. © UNICEF/2017/Chamois

Nandrianina and Vony from the mobile nutrition team verifying the nutritional status of Lamiaze using the weight-for-height ratio table. © UNICEF/2017/Chamois

Ravo and Lamiaze will return to the mobile nutrition team again next week and will continue to do so until he is back to full health.

UNICEF-Madagascar supports the Government’s National Nutrition Office through financial and technical assistance in deploying vehicles and health professionals, monitoring, assuring quality and providing essential drugs and nutrition supplies.

Thanks to UNICEF, three mobile nutrition teams have been deployed in the district of Ambovombe, covering 32 sites and a population of over 10,000 children under five years old.

Donor Feedback Form

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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: DANIEL ZIEGLER

Email: dziegler@unicef.org

***

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

1. 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?

2. 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?

SCORING: **5 indicates "highest level of satisfaction" while**

0 indicates "complete dissatisfaction"

3. 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?

4. 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?

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

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

Thank you for filling this form!