MALAWI

Nutrition Thematic Report
January - December 2016

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

1.0 Executive Summary

The Malawian Government has demonstrated strong political will and commitment to address the high prevalence of stunting in the country. Although the stunting rate has declined steadily since 1997, the significant reduction observed on stunting prevalence is not reflected in the absolute number of children with chronic malnutrition, which in 2015 (1,121,346) is still higher than in 1997 (1,062,650). According to the 2014 MDG End Line Survey, inequalities persist in Malawi, with a stunting prevalence of 49 percent among the poorest quintile compared to 34 percent in the richest quintile as well as rural/urban and geographic disparities. Wasting has improved over the years affecting only 2.7 percent of children under five years in 2015 as compared to 6 percent in 2000 (DHS 2000 and 2015). Underweight has also decreased from 25 percent in 2000 to now 11.7 percent in 2015/16.

According to the 2015 Malawi Demographic Health Survey, Malawi has made significant strides in stunting reduction in line with the global recommendation of 2 percent annual reduction. Stunting levels among children under age 5 are showing a decreasing trend from 47 percent in 2010 to 37 percent in 2015 (Malawi Demographic and Health Survey MDHS-2015/16), through continued technical and financial support from UNICEF to the Scaling up Nutrition (SUN) Movement which gained further momentum in 2016. Noteworthy is the decline in prevalence of anemia in women of child bearing age from 44 percent in 2004 to 32 percent in 2015 (MDHS, 2015/16). Despite the gains made in stunting and micronutrient supplementation, progress in Infant and Young Child Feeding (IYCF) is faltering. The 2015 MDHS is showing that the target of 80 percent of children 0-5 months being exclusively breastfed is not being met as exclusive breast feeding rates declined from 71 percent in 2010 to 61 percent in 2015 (MDHS, 2010 and 2015/16).

In 2016, Nutrition governance was strengthened, through the updating of policy and legal frameworks for nutrition. High level advocacy and engagement of key stakeholders in nutrition resulted in the successful updating of the National Nutrition Policy 2017-2021, and adoption of the policy by cabinet in November 2016. To support implementation of the National Nutrition Policy, a National Nutrition Strategic Plan and Monitoring and Evaluation (M&E) framework 2017-2021 is now in place which has clear targets for nutrition in line with the global World Health Assembly Targets and the Sustainable Development Goals (SDGs).

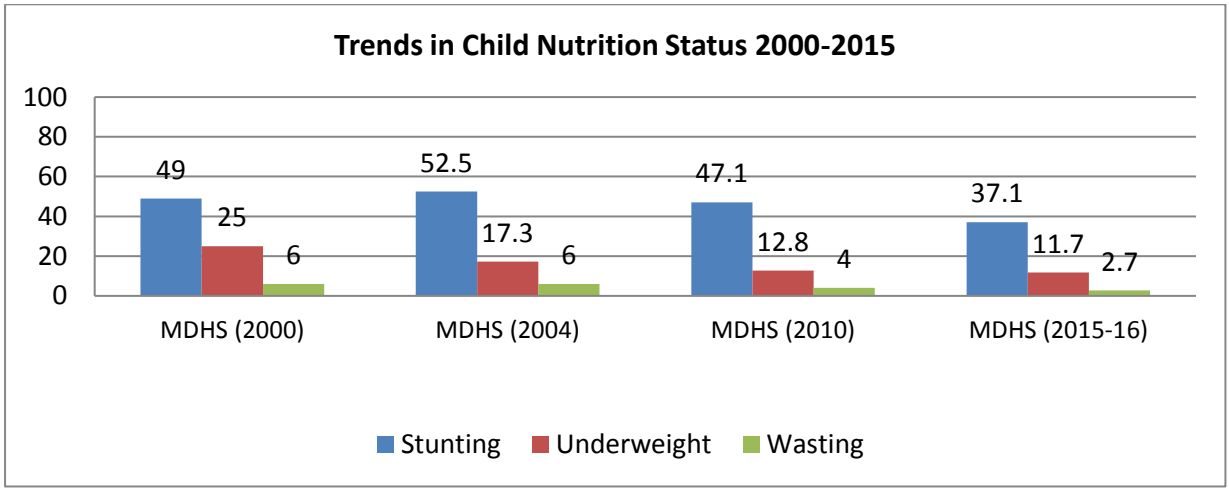
The lives of 40,225 children under five years of age who recovered from Severe Acute Malnutrition (SAM) have been saved due to the scale up of Community Based Management of Acute Malnutrition (CMAM) service provision in 2016 (National CMAM Database, 2016). Access to the CMAM program was increased to 707 facilities out of a target of 97 percent for 2016 in all 28 districts of Malawi. There are now 603 health facilities providing Outpatient Therapeutic Program (OTP) services and 104 Nutrition Rehabilitation Units (NRU). An increase in geographic access to CMAM services, availability of treatment supplies and intensification of mentoring, support and supervision has resulted in a 54 percent increase in CMAM admissions from 34,521 children in 2015 to 53,054 children (Male, 25,326; Female, 27,728) in 2016 (National CMAM Database, 2016).

To address micronutrient deficiency disorders, micronutrient interventions for children 6-59 months were successfully delivered through the bi-annual Child Health Days (CHDs) conducted in March 2016 (Round 1) and November 2016 (Round 2). During the first round of CHDs, 1,224,006 boys and 1,391,631 girls were reached with vitamin A supplementation which was 96 percent coverage against a target of 90 percent and an improvement from 92 percent coverage in 2015. Round 2 Child Health Days in 2016 achieved 91 percent coverage against a target of 90 percent. The target for de-worming in children 12-59 months was also achieved in Round 1 CHDs at 100 percent (1,154,084 boys and 1,273,989 girls) as compared to a target of 80 percent (Child Health Days Round 1 Report, MOH). Deworming coverage significantly improved from 55 percent in 2015 to 100 percent in 2016.

2.0 Strategic Context of 2016

Since Malawi joined the Scaling up Nutrition (SUN) movement in 2011, the Malawian government has demonstrated strong political will and commitment to address the high prevalence of stunting in the country. This led to the development of the SUN 1000 Special Days: National Nutrition Education and Communication Strategy (NECS) 2012-2017 whose goal was to reduce the prevalence of stunting among children less than two years of age to less than 20 percent over a five-year period (2011-2016). This goal was partially achieved as evidenced by the 10 percent stunting reduction between 2010 and 2015 from 47 percent to 37 percent (MDHS2015/16).

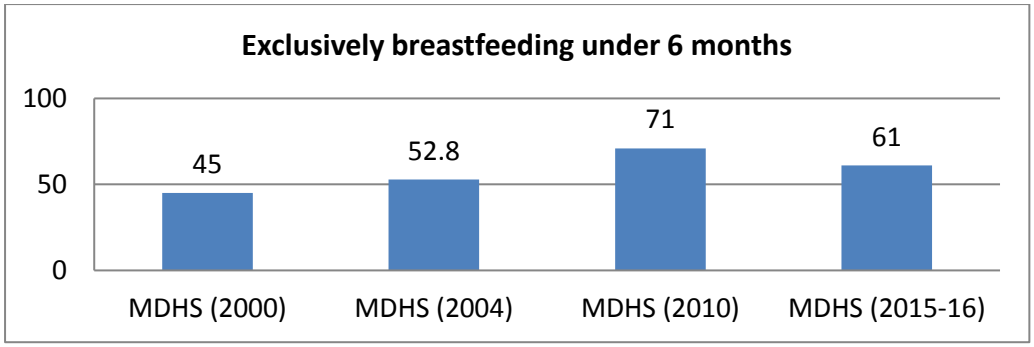
Although the stunting rate has declined steadily since 1997, according to the 2014 MDG End Line Survey, inequalities persist in Malawi, with a stunting prevalence of 49 percent among the poorest quintile compared to 34 percent in the richest quintile as well as rural/urban and geographic disparities. Wasting has improved over the years affecting only 2.7 percent of children under five years in 2015 as compared to 6 percent in 2000 (DHS 2000 and 2015). Underweight has decreased from 25 percent in 2000 to now 11.7 percent in 2015/16. Figure 1 below highlights the trends in child nutrition status from 2000 to 2015 based on the Malawi Demographic and Health Survey.



Source: Malawi Demographic and Health Survey 2000-2015/16

Figure 1: Trends in Child Nutrition Status 2000-2015

Of concern for Malawi is digressing trends in Infant and Young Child Feeding Practices. According to the 2015/16 MDHS, about seventy five percent of mothers initiate breastfeeding within 1 hour of birth and 61 percent exclusively breastfeed, a 10 percent reduction from rates in 2010. Continued breastfeeding up to two years of age has also decreased from 77 percent in 2010 to 72 percent in 2015. Figure 2 below, highlights that Malawi was making good progress in ensuring infants 0-5 years are exclusively breastfed, but in 2015, this trend has been reversed.

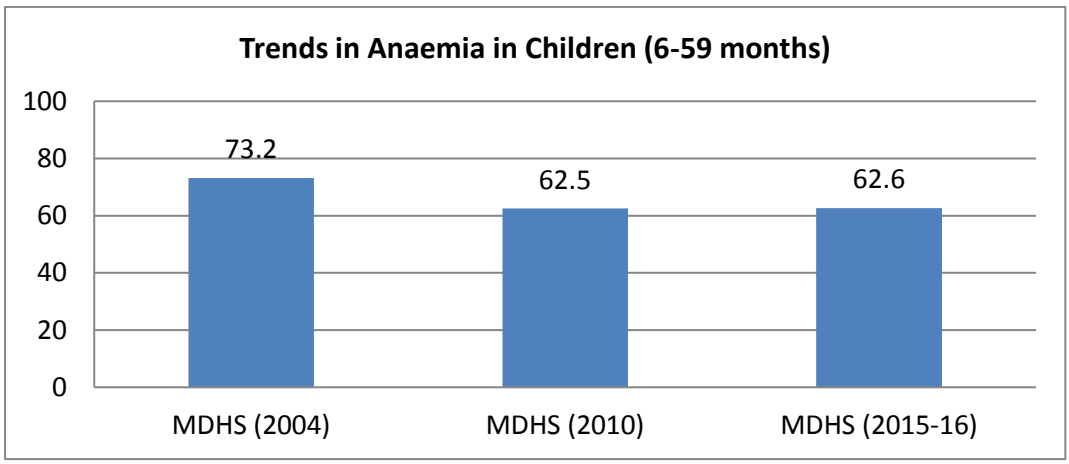


Source: Malawi Demographic & Health Survey 2000-2015/16

Figure 2: Trends in Exclusive Breastfeeding

One in 10 children 6-23 months (92 percent) do not meet the requirements for a minimum acceptable diet. The low quality of diet among children 6-23 months is due to a lack of a sufficient variety of food products to introduce into children's diets for appropriate complementary feeding as well as the quality of the food products (e.g. high level of aflatoxin in maize and groundnuts), coupled with low levels of education among women of child bearing age. A bottleneck analysis conducted in 2016, showed that only 23 percent of community based health workers have the capacity to provide appropriate infant and young child feeding counseling and support.

Stunting and anaemia together account for a major loss of intellectual potential and future productivity that affects the majority of Malawi's children (GOM 2014, Cost of Hunger Report 2015). According to the 2015 Cost of Hunger Study, stunting in Malawi was associated with a 10.3 percent annual loss in Gross Domestic Product (GDP) between 2008 and 2012 and with high school dropouts and class repetition. In addition to high levels of chronic malnutrition, micronutrient deficiencies remain a public health concern, especially Vitamin A and anaemia. Fifty eight percent of primary school children are vitamin A deficient and 25 percent are anaemic. Although anaemia has steadily declined from 73 percent in 2004 to 63 percent of children 6-59 months, this prevalence remains unacceptably high, especially when we see that a third (32 percent) of women of reproductive age are also anaemic (MDHS 2004-2015).



Source: Malawi Demographic and Health Survey 2004-2015/16

Figure 3: Trends in Anemia in Children 6-59 months

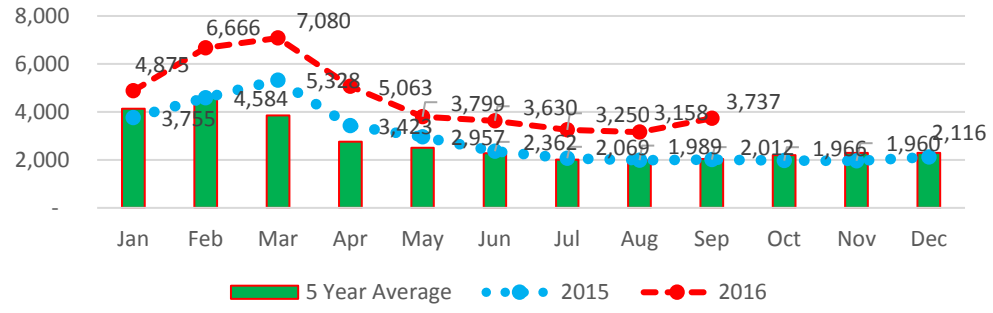
The immediate causes of undernutrition and micronutrient deficiencies include inadequate dietary intake as evidenced by only 8 percent of children 6-23 months meeting the minimum acceptable diet in Malawi

(MDHS2015/16) and infectious diseases leading to growth faltering. The underlying causes of undernutrition and micronutrient deficiencies include: 1) poor livelihood assets and choices (mostly crop-based with an increase pressure on natural resources particularly water and forests); 2) socio-economic issues (gender inequality in regards to intra-household food allocations and access to resources and education, HIV/AIDS, inadequate maternal, infant and young child feeding and care practices, inflation and price volatility); and 3) governance issues. The low social status of women is recognized as an important contributing factor to malnutrition and actions to empower women in the Malawian society and within households will help improve maternal and child nutrition.

Poor water and sanitation and extreme climatic events further increase the risk of outbreaks of communicable diseases, thus contributing to preventable undernutrition. Half of the population in Malawi have inadequate sanitation facilities and 15 percent lack access to safe water (MICS, 2014). Poor child spacing practices increase the risk of malnutrition and morbidity with high adolescent birth. Poor access and uptake of health services also significantly contributes to undernutrition. In Malawi, the health system is inadequately resourced and there is a precarious cycle of undernutrition and disease burden (malaria, diarrheal diseases and acute respiratory infections among others). The HIV/AIDS epidemic, infectious diseases and undernutrition are among the major factors contributing to high infant and under-5 mortality at 53/1,000 live births, under 5 mortality at 85/1,000 live births, respectively while the maternal mortality ratio at 574/100,000 live births also remains unacceptably high. Access to essential health care services among parents and young children remains limited and the lack of medical supplies and human resources further constrains the quality of services.

Over the past two decades, drought and flood events have increased in frequency, intensity, and magnitude with negative consequences for food and water security, water quality, energy availability, and sustainability of rural communities' livelihoods. Despite the humanitarian and developmental efforts and resources invested in improving production and food security in country, the impact of El Niño in the last two years has resulted in an unprecedented increase in food insecurity, prompting the declaration of a National State of Disaster. In 2015/16, 2.8 million people were declared food insecure, and in 2016/17 there was a significant increase in people affected by food insecurity where 6.5 million people (40 percent of the population) were food insecure, partly because of floods and widespread prolonged dry spells (MVAC 2015/16). The humanitarian context for Malawi resulted in a strong focus on the nutrition emergency response in 2015 and 2016, and a lesser focus on developmental programming.

While national rates of acute malnutrition are within acceptable levels, noteworthy is the current increasing trend in CMAM admissions in districts across the country. Figure 4 below highlights the increasing trend in the 2016 admissions.

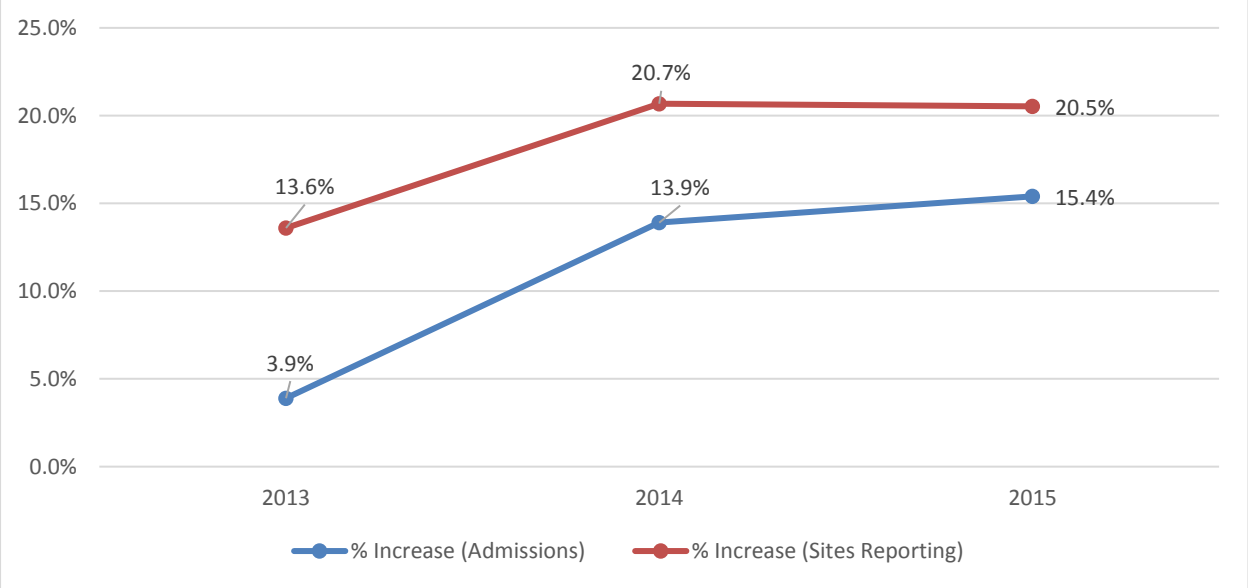


Source: National CMAM Database 2011-2016**5 Years Average (Average of Admissions from 2011 to 2015)

Figure 4. Trends in New SAM Admission (OTP+NRU) 2011-2016.

Figure 4 above shows that over the years most of the admissions are observed in the 1st quarter (Q1) of the year, which corresponds with the peak of hunger season. Almost 2 out of 5 admissions in the year occur in Q1 (38.3 percent); the greatest increase in admissions (for the 5 years average) is noted in February of every year; however, in 2015 and 2016, the greatest increase was noted in March. The number of admissions in a year tend to decrease with time (i.e. March through September), but start spiking slightly in October to December. However, a sharp increment is noted between January and March. Overall in 2016 (January - September), the number of admissions increased by 48.9 percent compared with 2015 over the same period; while, in the same period the number of admissions increased by 60.5 percent compared with the 5-years average.

The above mentioned increase in the 2016 CMAM admissions is a result of several factors which include active case finding and mass screenings which were introduced in December 2015; the prevailing food insecurity as a result of the floods of 2015; and the drought in 2016. It must also be noted that there has been a significant increment in the number of sites providing CMAM services and reporting since 2011. The average number of sites (OTP) reporting in 2011 was 400, in 2012 was 428, in 2013 was 484, in 2014 and 2015 was 516 and for 2016 the average is 592. The increase in the OTP sites reporting in 2016 as compared with 2011 is 48 percent which points to an increase in geographic access and expansion of the CMAM program and increased reporting rates. The increase in the NRU sites reporting in 2016 compared with 2011 is 4.1 percent, which shows a slight increment in reporting rate.



Source: National CMAM Database 2012-2015

Figure 5: Percent increase in admissions and sites reporting

Taking 2012 as the base year, then the percent increase in sites reporting in 2013 was 13.6 percent, in 2014 it was 20.7 percent and in 2015 it was 20.5 percent. Figure 5 above shows that there is a relationship between the percent increase in admissions and the percent increase in the sites reporting (which is expected). Additionally, worth noting is the significant relationship between the number of facilities reporting and the number of admissions, and using the regression model, the variation in admission accounted for by the increased number of facilities reporting is 14 percent (p=0.005) (*the correlation coefficient was 0.394 and a p-value of 0.005*) which is significant

and implies that the other 86 percent is being contributed by other factors such as intensive mass screening, and the worsening nutrition situation, among others..

3.0 Results in the Outcome Area

Output 2.2.1 Nutrition sector (Department of Nutrition, HIV and AIDS) in Malawi has the capacity to coordinate evidence based, equitable gender sensitive legislations and costed strategic plans for scaling-up nutrition interventions by 2017

In 2016, Nutrition governance was strengthened, through the updating of policy and legal frameworks for nutrition. High level advocacy and engagement of key stakeholders in nutrition resulted in the successful updating of the National Nutrition Policy 2017-2021, and adoption of the policy by cabinet in November 2016. To support implementation of the National Nutrition Policy, a National Nutrition Strategic Plan and M&E framework 2017-2021 is now in place which has clear targets for nutrition in line with the global World Health Assembly Targets and the SDGs. The development of a National Nutrition Policy and Strategic Plan 2017-2021, the Food and Nutrition Bill, and the updating of the Scaling Up Nutrition -National Education and Communication Strategy by the Department of Nutrition, HIV and AIDS (DNHA) demonstrates significant progress in creating an enabling environment for nutrition in Malawi.

In partnership with World Food Programme (WFP), FANTA and Action Against Hunger (ACF), UNICEF provided technical and financial support towards the updating of the National CMAM Guidelines in line with the latest World Health Organisation (WHO) guidance. The CMAM program evaluation was finalized in 2016 providing key recommendations to inform CMAM program planning and prioritization for 2017. Uptake of the CMAM evaluation and CMAM bottleneck analysis recommendations has resulted in the drafting and finalization of the National CMAM Operational Plan which is now finalized and will address key supply, demand and quality related bottlenecks in CMAM service delivery. Support towards implementation of the National CMAM Operational Plan is underway, and will be continued in 2017.

Output 2.2.2: The nutrition surveillance system composed of nutrition databases, real-time-monitoring and coverage surveys disaggregated by sex is effectively integrated into the District Health Information System 2 (DHIS II) by 2017

A series of consultative processes were conducted with key stakeholders at national, district and community/ facility levels to identify a list of key indicators for Nutrition specific and sensitive interventions and enabling environment factors contributing towards nutrition outcomes. Consultations resulted in the development of a harmonized list of indicators focused on nutrition specific as well as nutrition sensitive interventions. These indicators were aligned to national and international frameworks including the SDGs, and World Health Assembly (WHA) targets. The revised National Nutrition Monitoring and Evaluation framework has been aligned in such a way that it will serve as a common result framework under the SUN movement for nutrition for all stakeholders including Government (line-ministries), UN agencies, Development Partners and Non-Governmental Organisations (NGOs). There is now in existence a revised list of 61 indicators which were validated at the district level by district officials and at the national level by the sector and partners and adopted by the Government of Malawi as the monitoring framework for the National Nutrition Policy and Strategic Plan 2017-2021.

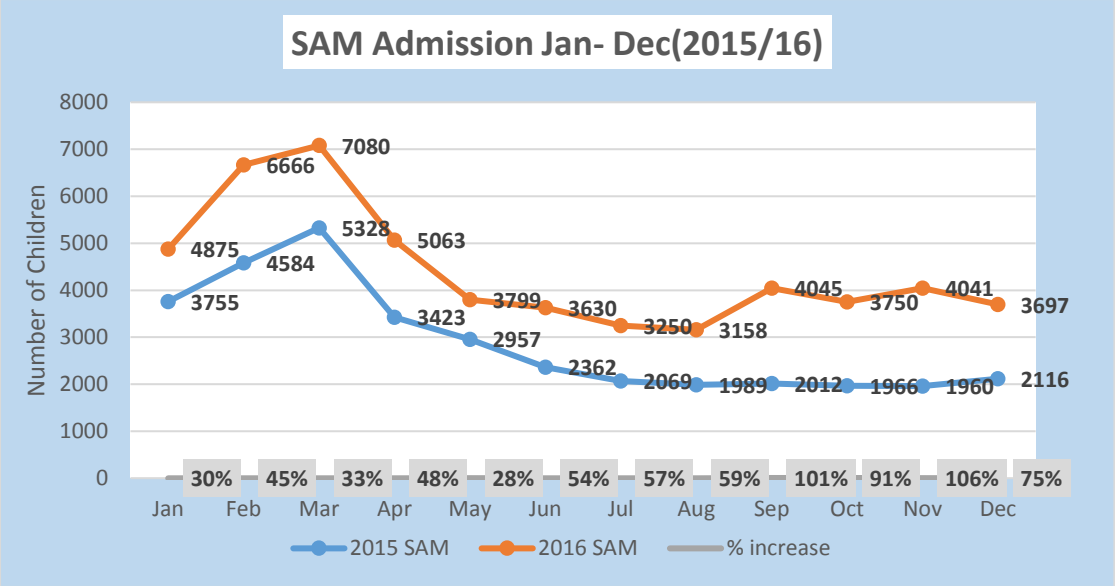
Figure 6: District Validation and consensus building meeting for revised M&E Framework

To date the Ministry of Health (MOH) and partners have relied on a parallel National CMAM database for reporting of CMAM program admissions and outcomes. Through technical support, the CMAM program data has been integrated into the District Health Information System 2 (DHIS-2) and there is now availability of data disaggregated by age for NRU, OTP and Supplementary Feeding Program (SFP) reports and sex-disaggregated data on new admissions with an online dashboard developed for easy visualization on progress of key indicators for the CMAM program.

In 2016, the MOH made notable progress in strengthening the National Nutrition Information Systems (NNIS) in Malawi as evidenced by timely availability of critical nutrition situation data and timely accurate reporting of CMAM program data. Additionally, to support monitoring of the nutrition emergency situation in partnership with DNHA and Lilongwe University of Agriculture and Natural Resources (LUANAR), UNICEF provided technical and financial support to successfully conduct two nutrition Standardized Monitoring and Assessment of Relief and Transitions (SMART) surveys in all 7 livelihood zones in the country. Results of the SMART surveys were used to inform the National Nutrition Emergency Response Plan for the nutrition cluster.

Output 2.2.3: Institutions (national – MoH and selected district) are able to plan, manage, and monitor for improved quality CMAM, micronutrient and IYCF service delivery at the time of crisis and natural disasters by 2017

The lives of 40,225 children under five years of age who recovered from SAM have been saved due to the scale up of CMAM Service provision in 2016 (National CMAM Database, 2016). Access to the CMAM program was increased to 707 facilities out of a target of 97 percent for 2016 in all 28 districts of Malawi. There are now 603 health facilities providing Outpatient Therapeutic program (OTP) services and 104 Nutrition Rehabilitation Units (NRU) and the increase in geographic access to CMAM services, availability of treatment supplies and intensification of mentoring, support and supervision has resulted in a 54 percent increase in CMAM admissions from 34,521 children in 2015 to 53,054 children (Male=25,326; Female=27,728) in 2016 (National CMAM Database, 2016). Figure 6 below highlights improvements in CMAM admissions in 2016 as compared to 2015.



Source: National CMAM Database

Figure 6: CMAM Admissions 2015 vs 2016

Between 2011 and 2015 CMAM admissions had stagnated ranging from 29,000 to 35,000 cases. For the first time in the past five years, the program managed to admit 53,054 children which is 64 percent of the 2016 target.

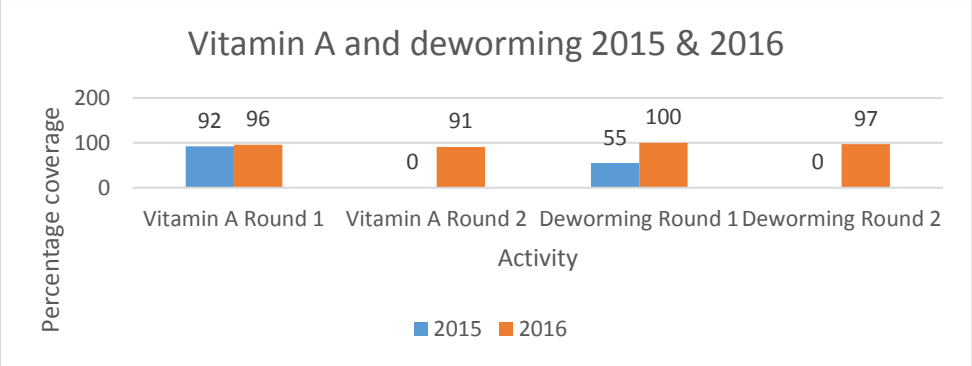
Budgetary allocation towards the nutrition sector remains sub-optimal and almost all CMAM program commodity procurement is externally funded. Nearly 50 percent of NRUs providing SAM treatment at Christian Health Association of Malawi (CHAM) (private sector) did not receive payments in 2016. To address this bottleneck, UNICEF mobilized resources for the procurement of life saving nutrition commodities for the treatment of children with SAM and 99,479 cartons of ready-to-use-therapeutic food (RUTF) were delivered to the last mile, i.e. to all health facilities in Malawi, ensuring no stock outs throughout the year. The provision of critical lifesaving nutrition supplies (Vitamin A, RUTF, F75, F100, ReSoMal, and amoxicillin) to the last mile reached 100 percent of facilities providing CMAM services across the country and resulted in a significant decrease in death rates within NRUs and OTPs. Of the 53,054 children admitted into OTPs and NRUs, a 90 percent cure rate was achieved which is above the >75 percent target and death rates significantly decreased from 10 percent in 2015 to 2 percent in 2016 meeting the target of <10 percent death rate set for 2016. Additional to the National progress in improved CMAM outcomes, is that 85 percent of CMAM facilities achieved Sphere Standards against an annual target of 80 percent.

A key demand related bottleneck is that only 50 percent of those identified children with SAM actually turn up at health facilities. To address the bottleneck of low uptake of CMAM services, UNICEF provided technical support that ensures integration of Communication for Development (C4D) into the community component of the CMAM program. As part of the humanitarian response, communication for development interventions contributed significantly during mass screening campaigns in mobilizing community members, particularly mothers and caregivers of under-five children, through community dialogues, social marketing campaigns and through community and faith based radio. Partnerships with NGO partners (World Vision, JPHEIGO, Concern Universal, Concern Worldwide, Story Workshop, Plan and Save the Children) were established as part of strengthening C4D nutrition emergency monitoring and coordination. A total of 66,625 people were mobilized using experiential social marketing techniques in 14 districts spread throughout the country. An estimated audience of over 7million listeners were reached with key messages through interactive programs on 11 radio stations (national, faith based and community radios).

Figure 7: Nutrition Screening for Acute Malnutrition in Dedza district, 2016

In collaboration with DNHA, the Ministry of Health Nutrition Unit, and the above mentioned NGO partners, UNICEF scaled up the nutrition emergency response in all 28 districts and this included community mobilization, mass screening and active case finding of children with acute malnutrition and referral into treatment. In addition, 21 UNICEF nutrition field monitors supported the government at the district level for implementation of the nutrition emergency response, resulting in early identification and referral for treatment of children with acute malnutrition. The first phase of the mass screening (January to May 2016) the highest number of children reached was 1,701,225 (94 percent) of the projected 1,802,203 children aged 6 to 59 months. 0.9 percent of these children had SAM and 3.3 percent had moderate acute malnutrition (MAM), which were managed in the CMAM program. Active case finding through the mass screening helped in early identification of children with acute malnutrition allowing for some children to be treated through the Supplementary Feeding Program (SFP) before they had deteriorated to SAM.

To address micronutrient deficiency disorders, micronutrient interventions for children 6-59 months were successfully delivered through the bi-annual Child Health Days (CHDs) conducted in March 2016 (Round 1) and November 2016 (Round 2). During the first round of CHDs, 1,224,006 boys and 1,391,631 girls were reached with vitamin A supplementation which was 96 percent coverage against a target of 90 percent and an improvement from 92 percent coverage in 2015. Round 2 Child Health Days in 2016 achieved 91 percent coverage against a target of 90 percent. Figure 7 below highlights the achievements in Vitamin A supplementation in children 6-59 months and deworming in children 12-59 months. The target for de-worming in children 12-59 months was also achieved in Round 1 CHDs at 100 percent (1,154,084 boys & 1,273,989 girls) as compared to a target of 80 percent (Child Health Days Round 1 Report, MOH). Deworming coverage significantly improved from 55 percent in 2015 to 100 percent in 2016.



Source: National Child Health Days Report 2015-2016

Figure 8: Vitamin A and Deworming Coverage 2015 vs 2016

Output 2.2.4: Capacities of implementing partners in selected districts enhanced to promote appropriate household behaviours and social change for maternal nutrition, infant and young child feeding and care practices to increase resilience in the community by 2017

Capacities of communities and caregivers have been enhanced for community level nutrition counselling and support. 2891 promoters against a target of 100 community health workers are now able to deliver social and behaviour change messages for maternal nutrition, infant and young child feeding practices. These promoters have reached 28,571 households. A total of 228 (161 Male, 67 Female) frontline workers were trained on IYCF against the total of 368 (62 percent) achieving the target of 60 percent for 2016. A total of 2,891 (462 Male, and 2429 Female) care group members were equipped with knowledge and skills for IYCF counselling (optimal breastfeeding i.e. exclusive breastfeeding and continued breastfeeding up to two years, complementary feeding, maternal nutrition, dietary diversification and WASH) reaching 28,571 households against a target of 26,563 reaching. Frontline workers, with support of community care group members, conducted growth monitoring sessions where 21,124 children were reached with community nutrition services which included growth monitoring and provision of behavior change communication on appropriate nutrition and water, sanitation and hygiene (WASH) practices. This has contributed to resilience building in communities and enhanced capacities of multi-sectoral structures for community based nutrition service delivery.

As a way of ensuring that the nutrition interventions reached the intended beneficiaries at the household level, a care group model is being implemented at the village level. This model brings nutrition interventions to the doorstep of the beneficiaries through the household visits done by the trained Cluster Leaders. However, the DNHA realized that different organizations were using different approaches of the model. This led to the need to harmonize the approach so that one evidenced based approach would be used by nutrition stakeholders. Led by the DNHA, a series of consultative meetings were conducted during which technical support was provided which resulted in the finalization of the Care Group Model training package and modules.

The capacity of five District Nutrition Coordinating Committee (DNCC) members from five districts (Mwanza, Mchinji, Rumphi, Mzimba South and Mzimba North) was enhanced for Infant and Young Child Feeding (IYCF) counselling and support using the revised care group package. The training equipped the participants with a harmonised approach to implementing interventions using the care groups. This has ensured the standardized approach is used and followed. As a result of the training, 1020 community level care groups were established in all 5 districts reaching 81,407 children and 30,708 pregnant and lactating women who are receiving bi-monthly IYCF counselling and support. Qualitative data from Health Surveillance Assistants' (HSA) reports during

monitoring visits, indicate that the practices of mothers for IYCF, WASH and Health have improved in these five districts.

Figure 9: Capacity building and monitoring visits to care group

Table 1: Results Assessment Framework for 2016

Indicator	Baseline 2015	Target 2016	Status	Assessment	Means of Verification
Children 0-5 months old who are exclusively breastfed	61 percent	61 percent	61 percent	🟢	MICS/DHS
Children 6-23 months provided with minimum dietary diversity	19 percent	30 percent	8 percent	🔴	MICS/DHS
Households consuming iodized salt (e.g. salt containing any iodine)	82 percent	85 percent	95 percent	🟢	MICS/DHS
Children 6-59 months covered with Vitamin A in semester 1	92 percent	95 percent	96 percent	🟢	Sector MIS
Children 12-59 months who received deworming tablets in semester 1	55 percent	80 percent	100 percent	🟢	Sector MIS
Children 6-59 months covered with Vitamin A in semester 2	92 percent	95 percent	83 percent	🟡	Sector MIS
Children 12-59 months who received deworming tablets in semester 1	55 percent	80 percent	100 percent	🟢	Sector MIS
Proportion of girls and boys between 6-59 months SAM cases received treatment as per national standards, in targeted districts	35 percent	50 percent	64 percent	🟢	Sector MIS

Existence of a national policy or plan targeting anemia reduction in women and girls	0	1	0		Sector Review
Existence of National protocols for the management of SAM based on WHO standards that includes CMAM available	0	1	1		Sector Review
Nutrition sector plan or policy that includes a risk management strategy to address disaster/crisis risk available	0	1	1		Sector Review
National Multisectoral Committee for Nutrition available and functional	0	1	1		Sector Review
CMAM Operation plan costed in place	0	1	1		Sector Review
National management information system that includes disaggregated (age, sex, urban/rural) data on nutrition available	0	1	1		Sector Review
Community health workers trained with UNICEF support to provide infant and young child feeding counselling services in the reporting year	0	100	228		Sector Review
Health facilities that provide SAM treatment services	585	731	707		Sector MIS
Health Facilities reaching SPHERE standards for SAM treatment (>75 percent cured, <15 percent defaulted, <5 percent died	66	80	85		Sector MIS
UNICEF-targeted children aged 6-59 months with SAM in humanitarian situations admitted to SAM programmes and recover	26400	65931	52439		Sector MIS
Proportion of mothers of children under two received counselling on key child caring practices in 8 districts (EBF, CF, HIV, sanitation , hygiene and health)	0	0	80		Sector Review

Key Strategic Partnerships and Inter-Agency Collaboration

Coordination of the National Nutrition Response was strengthened, as evidenced by the establishment of various nutrition governance structures to provide oversight and coordination functions, policy and technical guidance, and high level advocacy for resource allocation towards the National Nutrition Response. Technical support and facilitation of coordination meetings was provided to the following structures; Cabinet Committee on Sustainable Social Development which includes Nutrition, Principal Secretary Committee on Nutrition HIV and AIDS, Parliamentary Committee on Nutrition HIV and AIDS and the Government Development Partners Committee which resulted in nutrition being mainstreamed into key sectoral policies and strategies. In 2016, nutrition targets were effectively mainstreamed into ministries of health and agriculture.

In terms of UN coordination, notable progress was made in strengthening collaboration of UN agencies, UNICEF, WFP, WHO and the Food and Agriculture Organisation (FAO) towards Delivering as One (DOA). This resulted in effective joint planning and programming for Nutrition under Outcome 2.2 for the United Nations Development Assistance Framework (UNDAF) as well as an effective joint implementation of the nutrition emergency response. Progress was made in strengthening of government capacity for multi-sectoral coordination and ensuring that the National Multi-sectoral Committee for Nutrition is functional under the SUN umbrella. The UN Nutrition Thematic Group (UNICEF, WFP,WHO, and FAO) extended financial and technical support to DNHA in conducting a joint review of progress in implementation of the SUN movement, which resulted in four out of the five SUN networks compiling an annual SUN Self-assessment progress report for 2015. This stock taking has generated evidence on where gaps still exist in implementation of SUN in Malawi, and guided program prioritization for 2016-2017 for stakeholders in nutrition.

Through Renewed Effort Against Child Hunger and Undernutrition (REACH) funding, technical leadership was extended to DNHA which resulted in two of the planned SUN Learning Forums being successfully conducted in 2016 and allowed for districts to share best practices, lessons learnt, challenges and experiences in implementing Scaling up Nutrition activities. During the learning forum, district level coordination gaps were identified and resulted in DNHA developing a district level score card to define functionality of DNCCs as a way of improving accountability for district nutrition coordination committees. The score card was used to assess the functionality level of 20 of the established DNCCs in the country. Based on the identified gaps in coordination, the capacity of DNCCs were systematically strengthened, which resulted in improved nutrition coordination at district level.

Figure 10: SUN Learning Forum April 2016

At sub-national levels, technical support was provided towards strengthening the capacity of 20 District Nutrition Coordination Committees (DNCCs) and 3 City Councils. This has resulted in a systematic process of strengthening of the 20 DNCCs, based on their capacity gaps and resulted in improved DNCC capacity for multi-sectoral nutrition program planning, implementation, monitoring and evaluation. The strengthening of the capacity of the 20 DNCCs

has also resulted in strengthened collaboration amongst key line ministries and leveraging of other sector resources towards nutrition program targets at the district level. Resource pooling by DNCCs towards nutrition, has also resulted in a scale up in the coverage of high impact nutrition sensitive and nutrition specific interventions.

Value for Money

Value for Money was achieved in 2016 in four thematic areas, namely economy, efficiency, effectiveness and equity.

Economy: The use of UNICEF procurement procedures with existing partnerships within our supplies and logistics section, ensured nutrition commodities were procured at a lower cost. Procurement through the well-established UNICEF procurement systems and UNICEF's global procurement ensured the best-cost to point of service.

Efficiency: The systems strengthening approach for existing multisectoral DNCCs which are government representatives from agriculture, health, WASH, social services and nutrition enhanced efficiency of nutrition service delivery. The multi-sectoral approach and use of existing Government of Malawi and UNICEF structures for project delivery ensured leveraging of existing resources. Vehicles, office space, communication systems were available through UNICEF at reduced costs to the programme. Further programming efficiency was improved through cascading training of lower level cadres through the existing District food and nutrition structures, enabling lower cost training at the local level to work through existing structures.

Effectiveness: Nutrition specific interventions have been proven effective in delivering the intended nutritional outcomes. In 2016, nutrition funds were used to implement proven interventions that can address malnutrition among vulnerable populations. Lessons learned from the implementation of nutrition programme in Malawi by UNICEF and from sharing country experiences in multi-country initiatives helped in efficiently delivering nutrition services for greater programme effectiveness.

Equity: Last mile delivery of nutrition commodities to health facilities in all districts, ensured that children in all 28 districts in Malawi were able to have equitable access to treatment of Severe Acute Malnutrition services. Additionally, the monthly screening and active case finding at community level, ensured that at least 80 percent of children under five years were reached with community based screening of acute malnutrition including the most hard to reach areas of all districts in Malawi.

Lessons Learned, Constraints and Challenges

The key lesson learned in the implementation of nutrition interventions in the country is that enthusiasm and commitment to the project among Government is key for sustainability of the project Through the SUN learning forum, it was observed that the care group model adopted for implementation of nutrition activities is instrumental at the community level in ensuring positive infant and young child feeding practices. The model also ensures early identification of malnourished children, referral and action. Apart from that, the model also played a key role in promoting behaviour change regarding nutrition interventions and active DNCCs in the districts were key in achieving sustainable results in the care group model approach.

Another lesson from the support to DNCCs is that vertical and horizontal coordination are crucial for implementation of nutrition response. When coordination structures are capacitated implementation of nutrition specific and nutrition sensitive interventions is done in a manner that avoids duplication of efforts and results in efficiency in the use of resources.

Overall the policy environment is conducive, however there are nationwide challenges with the implementation of the nutrition policies due to financial and human resources constraints. The policy environment for IYCF implementation is good, however, there are many gaps at the implementation level. Capacity for IYCF service delivery remains low. To address the IYCF program implementation gap UNICEF will support the implementation of a nutrition mentorship program to address skills gaps in nutrition service delivery. Furthermore, the nutrition mentorship programme revealed gaps in availability of nutrition Information, Education and Communication (IEC) materials, these will be developed and will be informed by the finalized the nutrition C4D strategy.

The quality of data from the CMAM program continues to be of concern and requires that district health teams are further capacitated on data reporting. Advocacy for inclusion of key nutrition indicators into the national health information system and training for district health teams on data management will be implemented in 2017.

Health worker knowledge and skills for the management of acute malnutrition is limited, particularly in the NRU setting. Clinicians, nurses and community based health workers will be targeted with training on the updated CMAM guidelines in 2017.

Risk Assessment and Risk management

Partnerships remained a risk that was closely monitored in 2016. Ineffective partnership arrangements, weak partners, and being a difficult partner is a critical risk in delivery of a multi-sectoral nutrition programme. To manage this risk the UNICEF nutrition programme declined any partnerships that deviate from core priorities of UNICEF. Critical partnerships with Government ministries were enhanced through supporting technical, financial and human resources to help strengthen weak capacities.

4.0 Financial Analysis

In 2016, the Nutrition programme had a total planned budget of 3,670,890 USD. The table below shows planned budget per outcome area.

Table 2: Planned Budget for Outcome Area

Outcome Area 4: Nutrition
Malawi
Planned for the Country Program 2016 (in US Dollar)

Intermediate Results	Funding Type[1]	Planned Budget[2]
04-01 Infant and Young child feeding	RR	257,439
	ORR	
04-06 Nutrition # General	RR	220,001
	ORR	212,561
Unknown	RR	230,000
	ORR	2,750,889
Total Budget		3,670,890

[1] RR: Regular Resources, ORR: Other Resources - Regular

[2] Planned budget for ORR does not include estimated recovery cost

In total, 1 national committee supported the Nutrition programme through thematic funds in 2016. Table 3 shows the country-level thematic contribution to the Nutrition programme in 2016.

Table 3: Country-level thematic contributions to Outcome Area received in 2016

Outcome Area 4: Nutrition
Thematic Contributions Received for Outcome Area 4 by UNICEF Malawi in 2016
(in US Dollars)

Donor	Grant Number	Contribution Amount	Programmable Amount
Outcome 4: Nutrition		24,829	24,829
United Kingdom Committee for UNICEF	SC1499040061	24,829	24,829
		24,829	24,829

The Nutrition programme has five key results areas including Nutrition and emergencies. The table below outlines the expenditure during 2016 per results area, regular resources, other resources - regular, and other resources-emergency. While the largest amount was spent on nutrition and emergencies, a considerable amount was spent on general nutrition.

Table 4: Expenditures in the Outcome Area

Outcome Area 4: Nutrition
Malawi
2016 Expenditures by Key-Results Areas
(in US Dollars)

	Expenditure Amount			
Organizational Targets	**Other Resources-Emergency**	**Other Resources - Regular**	**Regular Resources**	**All Programme Accounts**
04-01 Infant and Young child feeding		283,527	97,781	381,308
04-02 Micronutrients		655,662	60,525	716,187
04-04 Community-based management of acute malnutrition	262,586	219,606	449,852	932,044
04-05 Nutrition and emergencies	3,971,012	3,401,615	152,355	7,524,982
04-06 Nutrition # General		770,597	385,364	1,155,961
Outcome Area 4: Nutrition	4,233,598	5,331,006	1,145,878	10,710,482

Thematic expenses per programme area are outlined in table 5 below.

Table 5: Thematic expenses by programme area

Outcome Area 4: Nutrition
Malawi
Thematic Expenses by Programme Area
(in US Dollars)

NUTRITION	
Other Resources - Emergency	
04-05 Nutrition and emergencies	654,228
Other Resources - Regular	
04-01 Infant and Young child feeding	977
04-05 Nutrition and emergencies	10,246
NUTRITION Total	**665,452**

For an in-depth understanding of the expenses by intervention it is helpful to look at table 6 which outlines the expense by intervention areas.

Table 6: Expenses by Specific Intervention Codes

Outcome Area 4: Nutrition
Malawi
Expenses by Specific Intervention Codes
(in US Dollars)

Prorated Outcome Area	04 Nutrition
Specific Intervention Area	Expense
04-01-01 Infant and young child feeding implementation (including BFHI)	333,928
04-02-01 Vitamin A supplementation	403,669
04-02-02 Elimination of iodine deficiency	98,627
04-02-03 Staple food and condiment fortification	37,815
04-02-04 Home fortification	99,461
04-04-01 Treatment of Severe Acute Malnutrition	730,028
04-05-01 Nutrition # cluster coordination in humanitarian response	7,247,179
04-06-01 Nutrition # General	930,352
04-06-04 Nutrition surveys, assessments and surveillance	46,422
04-06-05 Routine nutrition information systems and reporting	18,352
08-01-01 Country programme process	55,770
08-01-06 Planning # General	3,186
08-02-05 Other multi-sectoral household surveys and data collection activities	35,538
08-02-08 Monitoring # General	6,274
08-03-01 Cross-sectoral Communication for Development	31,212
08-04-02 Community based child care	4,389
08-09-06 Other # non-classifiable cross-sectoral activities	465,984
08-09-07 Public Advocacy	4,048

08-09-08 Engagement through media and campaigns	1,487
08-09-10 Brand building and visibility	15,040
08-09-11 Emergency preparedness and response (General)	335,652
10-07-12 Management and Operations support at CO	115,018
10-07-13 ICT capacity in CO	26,563
1021 Micronutrient supplementation	1,660
1067 Manage and treat Severe Acute Malnutrition	2,604
1102 Nutrition Policies, legislations, plans and budgets	3,316
6901 Staff costs (includes specialists, managers, TAs and consultancies) for multiple Focus Areas of the MTSP	14,985
7921 Operations # financial and administration	-358,079
7971 Communication (DOC)	2
Grand Total	**10,710,482**

The planned budget for 2016 is broken down into planned and funded from RR and ORR funds in table 7 below.

Table 7: Outcome Area 4: Nutrition Planned Budget and Available Resources 2016

Outcome Area 4: Nutrition
Malawi
Nutrition Planned Budget and Available Resources 2016
(in US Dollars)

Intermediate Result	Funding Type	Planned Budget	Funded Budget	Shortfall
04-01 Infant and Young child feeding	ORR		283,527	0
	RR	257,439	97,781	159,658
04-02 Micronutrients	ORR		655,662	0
	RR		60,525	0
04-04 Community-based management of acute malnutrition	ORE		262,586	0
	ORR		219,606	0
	RR		449,852	0
04-05 Nutrition and emergencies	ORE		3,971,012	0
	ORR		3,401,615	0
	RR		152,355	0
04-06 Nutrition # General	ORR	212,561	770,597	0
	RR	220,001	385,364	0
Unknown	ORR	2,750,889	0	2,750,889
	RR	230,000	0	230,000
Grand Total		**3,670,890**	**10,710,482**	**3,140,547**

5.0 Future Work plan

The nutrition plans for 2017-2018 prioritizes addressing stunting as identified in the National Nutrition Policy and Strategic Plan 2017-2021. This will be done through scaling up of a multi-sectoral community based model for stunting reduction. The approach involves capacitating DNCCs at lower implementation levels to identify context specific drivers of stunting and development of micro-plans to address them. UNICEF is also planning on strengthening the nutrition information systems to ensure evidence based program planning and prioritization. The declared drought emergency has also taken the focus for 2016 towards intensifying efforts to screen, identify and refer children under five years for the treatment of severe acute malnutrition, this may require reprogramming efforts towards SAM prevention and management. UNICEF will also support strengthening the nutrition emergency planning, response and information management throughout the year. For the period 2017-18, a planned budget of US$ 33million is required and so far US$ 22.5 million has been secured. To overcome funding constraints, UNICEF will continue to conduct resource mobilization activities targeting local and international donors. Leveraging of resources by entering into partnerships will increase efficiency of the available few resources.

Table 8: Planned Budget 2017/18

Planned Budget (2017-20118)	Available Budget	Funding Gap
US$ 33 million	US$22.4 million	US$ 9million

6.0 Expression of Gratitude

UNICEF would like to express its sincere gratitude to all of its donors for the generous support provided to support the implementation of nutrition interventions in Malawi. The achieved results demonstrate the need to continue with multi sectoral coordination for improved nutrition outcomes. We anticipate scale up of community-based approaches to achieve equity for women and children. These approaches have proved highly successful as illustrated by the results of this project.

Annex 1: Human Interest Story

BRIDGING THE KNOWLEDGE GAP: AN AMMUNITION IN COMBATING CHILD MALNUTRITION

By Tamanda Masambuka

Malawi, Nkhatabay: 65 year old, Chimango Mhone, eloquently explains to the care givers gathered at the court yard on maternal, infant and young child malnutrition, clarifying its dangers, causes, myths and prevention measures. Chimanya places emphasises on prevention measures mainly locally available foods that mothers can use for complementary feeding and preparing meals containing six food groups. Basing on her presentation, one would think she is a trained teacher or better still a nutrition expert, however, nothing could be further from the truth.

Background

Chi mango Mhone, is a volunteer, under the Sanga Care Group, an initiative by Nkhatabay District Council with support from UNICEF.

UNICEF Malawi/2016/Masambuka. Mhone, 65 year old, delivering a lecture on complementary feeding and six food groups to care givers gathered at the chief's court vard.

Formed in 2014, after undergoing a training in message dissemination on infant, child and maternal nutrition, Chimango and fellow members of Sanga Care Group disseminate messages and encourage community members to practice good maternal, infant and young child nutrition practices. Among others the practices include antenatal care and safe delivery for pregnant women, exclusive breastfeeding for children under six months, supplementary feeding for children above six months, eating meals from six food groups and good hygiene practices especially hand washing.

Message Dissemination

Apart from calling for meetings to deliver the messages, Chimango makes house calls at least twice a month to 25 households under her care, traveling long distances on foot under the scorching sun and sometimes fierce rain. Chimango goes further to teach the mothers how to use locally available products like bananas and fish to prepare nutritious meals for their children and family.

“There is a misconception that nutritious meals can only be prepared using products people purchase from shops. I always tell my colleagues that that is a lie. I actually prove that to them by teaching them how to prepare nutritious meals with products in this village, some which they don’t even need to buy,’ says Chimango.

Impact on Community

Nelly Mphande, a community member of Sanga, testifies on the impact Chimango is having on her life and community. Nelly says Chimanga taught her to use locally available resources to prepare nutritious meals with six food groups. Through Chimango she also learnt to prepare porridge mixed with small fish locally available in Nkhatabay, which she feeds her one year old daughter.

UNICEFMalawi/2016/Masambuka
Nelly holding one year old daughter at their home.

“At first I used to prepare porridge for my one year old daughter by only using maize grain flour. I noted she was not gaining weight. Chimango however taught me to add small fish locally available in this village to make it more nutritious. Now she gained weight and has never been healthier,” says Nelly.

UNICEF support

UNICEF is supporting the Government of Malawi through District Councils in implementing social behaviour change intervention to fight child malnutrition in communities across three districts of Neno, Phalombe and Nkhatabay.

This is done through building the capacity of Health Surveillance Assistants (HSAs) and Community Care Group Volunteers by providing them with trainings in disseminating messages on maternal, infant and child nutrition.

Annex 2: Donor Feedback Form

Report Feedback Form

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

Please return the completed form back to UNICEF by email to:
Name: Roisin De Burca
Email: rdeburca@unicef.org

***

Title of Report/Project: Outcome 4: Nutrition Thematic Report

UNICEF Office: Malawi

Donor Partner:

Date:

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

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

5	4	3	2	1	0

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

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

5	4	3	2	1	0

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

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

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

5	4	3	2	1	0

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

To what extent does the report meet your expectations with regard to reporting on results?

5	4	3	2	1	0

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

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

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

Thank you for filling this form!