UNICEF Support to Nutrition in Emergency Response in Malawi

<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMZ</td>
<td>Federal Ministry of Economic Cooperation and Development</td>
</tr>
<tr>
<td>C4D</td>
<td>Communication for Development</td>
</tr>
<tr>
<td>CCCs</td>
<td>Core Commitments for Children</td>
</tr>
<tr>
<td>CLA</td>
<td>Cluster Lead Agency</td>
</tr>
<tr>
<td>CMAM</td>
<td>Community Based Management of Acute Malnutrition</td>
</tr>
<tr>
<td>CHAM</td>
<td>Christian Health Association of Malawi</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development UK</td>
</tr>
<tr>
<td>DNCC</td>
<td>District Nutrition Coordination Committee</td>
</tr>
<tr>
<td>DNHA DONUTS</td>
<td>Department of Nutrition HIV and AIDS Donors Group for Nutrition Security</td>
</tr>
<tr>
<td>IP</td>
<td>Implementing Partner</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HSA</td>
<td>Health Surveillance Assistant</td>
</tr>
<tr>
<td>MAM</td>
<td>Moderate Acute Malnutrition</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MUAC</td>
<td>Middle Upper Arm Circumference</td>
</tr>
<tr>
<td>MVAC</td>
<td>Malawi Vulnerability Assessment Committee</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
</tr>
<tr>
<td>NRU</td>
<td>Nutrition Rehabilitation Unit</td>
</tr>
<tr>
<td>OTP</td>
<td>Outpatient Therapeutic Program</td>
</tr>
<tr>
<td>RUTF</td>
<td>Ready to Use Therapeutic Food</td>
</tr>
<tr>
<td>SAM</td>
<td>Severe Acute Malnutrition</td>
</tr>
<tr>
<td>SCTP</td>
<td>Social Cash Transfer Program</td>
</tr>
<tr>
<td>SFP</td>
<td>Supplementary Feeding Program</td>
</tr>
<tr>
<td>SMART</td>
<td>Standardized Monitoring and Assessment of Relief and Transitions</td>
</tr>
<tr>
<td>SWET</td>
<td>Story Workshop Educational Trust</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Program</td>
</tr>
</tbody>
</table>
UNICEF and its partners undoubtedly saved thousands of lives.
UNICEF Malawi has been committed to a strategic, coordinated and effective response to humanitarian emergencies in Malawi for decades. The Core Commitments for Children in Humanitarian Action (CCCs) is a global framework for humanitarian action for children undertaken by UNICEF and its partners.

In Malawi, recent flood and drought emergencies left thousands of children malnourished. UNICEF was at the forefront of the humanitarian response, adhering to the CCCs, and working hard to improve the health and wellbeing of affected children. Despite many challenges and constraints, UNICEF and its partners undoubtedly saved thousands of lives.

UNICEF will continue to strive when it comes to emergency response, humanitarian relief and building resilience among the women and children of Malawi. Our goal is to ensure Malawi’s children are cared for and protected, and come to enjoy the bright future they are entitled to.

Johannes Wedenig
UNICEF Representative for Malawi
Malawi experienced a series of natural disasters from 2015 to 2017, including flooding followed by dry periods and droughts. Across the region, Malawi was one of the worst hit countries by an El Nino weather event. The series of disasters decimated livelihoods, displaced people from their homes and left much of the country food insecure. Malnutrition levels among children were at the highest levels in decades. Some 25 out of 28 districts in Malawi were affected. In October, 2015, 2.8 million individuals were declared food insecure by the Malawi Vulnerability Assessment Committee (MVAC). In April 2016, the President of Malawi declared a state of disaster following crop failures that left some 6.5 million people food insecure and in need of immediate humanitarian assistance.

Globally, UNICEF is the Nutrition Cluster Lead Agency (CLA), but in Malawi the Department of Nutrition, HIV and AIDS leads the nutrition cluster with UNICEF as co-lead. UNICEF has the responsibility of ensuring the participation of key humanitarian partners. UNICEF is also charged with establishing and maintaining humanitarian coordination, lead planning, strategy development, and advocacy and resource mobilization within the nutrition sector. Further, UNICEF is responsible for acting as the provider of last resort – subject to access, security and availability of funding – to meet agreed priority needs. Operationally, UNICEF is responsible for providing technical support and the supply of aid to manage severe acute malnutrition (SAM) among children under five. UNICEF supports communities through outpatient treatment programmes (OTPs), inpatient care nutrition rehabilitation units (NRUs), protection, promotion and support of infant and young feeding practices (IYCF), micro-nutrient supplementation (vitamin A campaigns), and provides therapeutic nutrition products, anthropometric equipment and essential drugs needed for treatment of SAM.
Lives of 78,635 children, who suffered from SAM were saved

1.1 million children were reached every month through active case finding campaign and community mobilization, total 426,074 children with SAM and MAM conditions were referred to health facilities.

SPHERE minimum standards were maintained
Cure rate >75%;
Defaultter rates <15%;
Death rates <10%

“UNICEF scaled up emergency nutrition response to meet increasing needs of children affected by drought in Malawi, and supported 611 Outpatient Therapeutic Program Centers, 104 Nutrition Rehabilitation Units and regularly conducted active case finding and community mobilization in catchment communities”
In line with the overall strategic approach of the humanitarian response, UNICEF focused on priority nutrition in emergencies (NiE) interventions including the provision of lifesaving nutrition services for SAM children across 28 districts. In addition, UNICEF procured and delivered life-saving therapeutic feeding supplies to 611 OTPs and 104 NRUs across the country. A healthy pipeline of life-saving therapeutic supplies for the management of SAM was achieved and maintained as part of the emergency response. The most vulnerable groups experiencing SAM were deliberately targeted including food insecure districts in rural communities. Mass screening for identification of children with acute malnutrition was conducted in every community. UNICEF ensured that every child under five years in targeted districts was reached. The community mobilization strategy ensured that households that would not have otherwise sought treatment were reached. In addition, hard-to-reach areas were accessed with life-saving nutrition treatment. As part of UNICEF’s commitment to saving lives, women and children were screened for malnutrition. UNICEF supported treatment of acute malnutrition, promoted age appropriate infant and young child feeding (IYCF) practices, and worked to prevent micronutrient deficiencies.

UNICEF supported the Ministry of Health (MoH) in the implementation of the Community Based Management of Acute Malnutrition (CMAM) programme, which remained crucial to child survival, especially during the drought period. Across Malawi’s 28 districts, UNICEF supported 611 health facilities with outpatient therapeutic program (OTP) out of total 639, representing a coverage rate of 96 per cent. UNICEF also supported 104 nutrition rehabilitation units (NRU), which serve as stabilization centres for SAM cases with complications. This scaled up approach was adopted after floods swamped the country in 2015, followed by dry spells and drought. The Government of Malawi (GOM), through the MoH, led the response to the crisis while UNICEF and the World Food Programme (WFP) were the main partner agencies. During the emergency, UNICEF established partnership agreements with NGOs in targeted districts to ensure adequate support was given to the MoH in mobilising the community, case detection and referral of children identified with SAM to health facilities.

From December, 2015, to July, 2017, 21 nutrition field monitors were recruited to support coordination, implementation and monitoring of mass screening efforts. They also worked on supply preposition and quality assurance activities within the CMAM programme, in all 28 districts in the country. The mass screening drive, from December, 2015, to May 2016, reached 1,802,203 children aged 6-59 months representing 94 per cent of those targeted. Of the children screened, 0.9 per cent were identified with SAM and 3.3 per cent had moderate acute malnutrition (MAM) which were managed in CMAM programme.
In Malawi, the CMAM programme was initiated in 2006. The MoH has declared it an essential part of the provision of health services in the country. However, the government has faced huge challenges sustaining the programme with supplies and commodities. To date, the MoH remains fully dependent on support from UNICEF for lifesaving therapeutic supplies for treatment of SAM. It also depends on WFP for supplementary feeding supplies and all logistics related issues. Donor support played a fundamental role in this lifesaving response and helped maintain the high quality humanitarian response.
HOW UNICEF APPROACHED THE SITUATION

Relevance and Appropriateness: During the emergency response and subsequent review of the situation, it was determined that scaled up CMAM programmes are a relevant and effective approach for addressing SAM in Malawi. The implementation of CMAM in Malawi has resulted in a high success rate for treating children with SAM.

UNICEF’s Technical and Organizational Support: UNICEF responded rapidly to the immediate needs of vulnerable children. In a short time span, UNICEF established partnerships with NGOs and began monitoring the community through mass screening, active case detection and referrals to facilities. Health facilities were kept well equipped with lifesaving therapeutic commodities, with deliveries to all 715 facilities occurring every month. Longer term resource allocation to the CMAM programme meant strengthening the human resources required to provide quality treatment and care, and ensure supplies were delivered using the existing MoH supply chain.

Effectiveness, Coverage and Quality of Services: The partnerships among communities, the Department of Nutrition HIV and AIDS (DNHA), UNICEF, WFP and NGOs successfully supported emergency response to the malnutrition epidemic, reaching 1.1 million children every month with a mass screening campaign. Some 2.8 million children were also reached through child health days, which provided micronutrient supplementation. The geographic coverage was 96 per cent for OTP and 100 per cent for the NRU. The geographic coverage of SAM cases during the program was about 60 per cent, as per the Sphere standards – a coverage rate above 50 per cent in a rural program is considered good. All program outcome indicators were maintained within the Sphere standards i.e. >75 per cent for Cure, <15 per cent for Default and <10 per cent for During the emergency response from October 2015 to June 2017 the cure rate remained 91.9 per cent (78,635); defaulter rate: 4.2 per cent (3,561); death rate: 2.1 per cent (1,826) and non-response: 1.8 per cent (1,582).

Information and Monitoring: District and facility level data managers were supported by the Nutrition Cluster, coaching and dedicated monitoring and evaluation focal persons. During the response period, routine data quality assurance was conducted throughout the country with the aim of verifying CMAM data quality, identifying areas of weaknesses and improvement of data quality. Although CMAM data was found to be of satisfactory quality, several issues were identified such as low utilization of data, inadequate capacity of workers at the facility level when it came to data management, and limited review of the data quality at the district level.

Capacity Development: UNICEF helped update the CMAM guidelines in line with global guidance. UNICEF also developed capacity in the health field by helping add 4,296 health care providers (including clinicians, nurses, home craft workers and health surveillance assistants). Capacity development was also done at every level for last mile delivery systems, CMAM stock monitoring and use of the rapid pro system.

Value for Money: Mass screening enabled moderate acute malnutrition (MAM) cases to be identified and treated before they progressed to the severe stage. Treatment of a child with SAM costs three times as much as the cost of treating a child with moderate malnutrition. Savings were achieved through procurement of RUTF using a certified in-country production facility which had a long-term agreement with UNICEF. In the same way, savings were achieved through partnerships with organisations which were already working in affected districts.
RESPONSE PLANNING AND EXECUTION

National Level Planning and Coordination
Coordination of the emergency response, including malnutrition case detection, screening and referral of children, was done by the Department of Nutrition HIV and AIDS (DNHA) and MoH at the national level. UNICEF’s leadership role continued throughout the entire emergency.

District Level Coordination
Smooth coordination among stakeholders, with support from national level offices, created an environment that enabled successful mass screening and case detection by health surveillance assistants and care group volunteers. District Nutrition Coordination Committees (DNCCs) provided support to all individuals delivering services to communities. DNCC meetings developed district implementation plans for implementing partners for the mass screening drive.

Mass Screening
Case detection through mass screening resulted in early identification of children with acute malnutrition and referral to CMAM facilities for treatment. Mass screening also directed children to supplementary feeding programmes before they deteriorated. UNICEF worked with partners including World Vision, JPHEIGO, Concern Universal, Concern Worldwide, Story Workshop, Plan and Save the Children on strengthening C4D, emergency monitoring and coordination. Communication for development interventions included community dialogues, social marketing campaigns and community and faith based radio announcements. These contributed to mobilising community members, particularly mothers and caregivers of children under five, to have their children screened for malnutrition.

Outpatient Therapeutic Program (OTP)
UNICEF provided support to 611 health facilities - out of 639 - which treated children for SAM. This represented a geographic coverage rate of 96 per cent of the health facilities in Malawi. The treatment coverage of under five children with SAM during the program was about 60 per cent. As per Sphere standards, a treatment coverage of above 50 per cent in rural program is considered good. The success rate in OTPs was overall 91 per cent, with 78,635 children successfully treated between October, 2015, and June, 2017.

Nutrition Rehabilitation Unit (NRU)
Through UNICEF support and MoH leadership, 104 nutrition rehabilitation units, with 100 per cent geographic coverage, provided lifesaving inpatient treatment care to under five children with SAM with medical complications. The overall successful treatment rates was 88 per cent between October, 2015, to June, 2017. The NRU capacity building plan was triggered by several rapid assessments and a set of recommendations provided by the assessors. With help from the Christian Health Association of Malawi (CHAM) and Action Contre la Faim (ACF), UNICEF increased the technical capacity of health workers in the NRUs across the country. At the same time, 110 NRU emergency resources kits were procured to enhance the quality of service delivery. The high death rates in NRUs at the beginning of drought emergency got the attention of authorities and triggered a huge emergency response. During the first three months of the response the death rates were controlled within Sphere thresholds. The number of people dying from malnutrition-related illnesses was recorded to identify trends and ensure timely and appropriate action was taken to prevent further deaths.

The Nutrition Cluster engaged partners in the planning process for the flood and drought emergency response. Through technical support provided by UNICEF, the Nutrition Cluster developed two Nutrition Cluster response plans. The first plan was developed to cover the period October, 2015, to April, 2016, while the second plan was developed after the declaration of the drought emergency. During the entire response period, the Nutrition Cluster met on a monthly basis. Specific actions were identified while compliance with the meeting schedule ensured accountability. The minutes of the meetings were disseminated to all stakeholders through emails and web posts. The Nutrition cluster was rated as one of the best performing clusters which achieved the results and adhered to all seven globally agreed core cluster functions.
Micronutrient Interventions
To address micronutrient deficiency disorders, UNICEF supported micronutrient interventions for children 6-59 months through biannual child health days conducted in March 2016 (round 1) and November (Round2) 2016. During the first round, 1,224,006 boys and 1,391,631 girls were reached with vitamin A supplementation, some 97 per cent coverage of those targeted. The target for de-worming children aged 12-59 months was also achieved during round 1 with 1,154,084 boys and 1,273,989 girls reached.

Data Management
Tally sheets for children aged 6 to 59 months, who were screened for malnutrition, were summarised in the health surveillance assistant (HSA) monthly reports. The data was summarised and broken down by catchment area before being submitted to health facilities, and from there to the local district office, after consolidation into a facility summary report. The reports were reviewed before being sent to local district HMIS by the 5th of every month.

Quality Control
Cumulative reports were compiled and presented to District Health Management Team (DHMT) for approval; after the endorsement by DHMT district reports were submitted to central level HMIS. All oedema cases detected were verified by a senior HSAs, a district nutritionists and a UNICEF field monitor.

Micronutrient Interventions
To address micronutrient deficiency disorders, UNICEF supported micronutrient interventions for children 6-59 months through biannual child health days conducted in March 2016 (round 1) and November (Round2) 2016. During the first round, 1,224,006 boys and 1,391,631 girls were reached with vitamin A supplementation, some 97 per cent coverage of those targeted. The target for de-worming children aged 12-59 months was also achieved during round 1 with 1,154,084 boys and 1,273,989 girls reached.

Data Management
Tally sheets for children aged 6 to 59 months, who were screened for malnutrition, were summarised in the health surveillance assistant (HSA) monthly reports. The data was summarised and broken down by catchment area before being submitted to health facilities, and from there to the local district office, after consolidation into a facility summary report. The reports were reviewed before being sent to local district HMIS by the 5th of every month.

Quality Control
Cumulative reports were compiled and presented to District Health Management Team (DHMT) for approval; after the endorsement by DHMT district reports were submitted to central level HMIS. All oedema cases detected were verified by a senior HSAs, a district nutritionists and a UNICEF field monitor.

Micronutrient Interventions
To address micronutrient deficiency disorders, UNICEF supported micronutrient interventions for children 6-59 months through biannual child health days conducted in March 2016 (round 1) and November (Round2) 2016. During the first round, 1,224,006 boys and 1,391,631 girls were reached with vitamin A supplementation, some 97 per cent coverage of those targeted. The target for de-worming children aged 12-59 months was also achieved during round 1 with 1,154,084 boys and 1,273,989 girls reached.

Data Management
Tally sheets for children aged 6 to 59 months, who were screened for malnutrition, were summarised in the health surveillance assistant (HSA) monthly reports. The data was summarised and broken down by catchment area before being submitted to health facilities, and from there to the local district office, after consolidation into a facility summary report. The reports were reviewed before being sent to local district HMIS by the 5th of every month.

Quality Control
Cumulative reports were compiled and presented to District Health Management Team (DHMT) for approval; after the endorsement by DHMT district reports were submitted to central level HMIS. All oedema cases detected were verified by a senior HSAs, a district nutritionists and a UNICEF field monitor.

Micronutrient Interventions
To address micronutrient deficiency disorders, UNICEF supported micronutrient interventions for children 6-59 months through biannual child health days conducted in March 2016 (round 1) and November (Round2) 2016. During the first round, 1,224,006 boys and 1,391,631 girls were reached with vitamin A supplementation, some 97 per cent coverage of those targeted. The target for de-worming children aged 12-59 months was also achieved during round 1 with 1,154,084 boys and 1,273,989 girls reached.

Data Management
Tally sheets for children aged 6 to 59 months, who were screened for malnutrition, were summarised in the health surveillance assistant (HSA) monthly reports. The data was summarised and broken down by catchment area before being submitted to health facilities, and from there to the local district office, after consolidation into a facility summary report. The reports were reviewed before being sent to local district HMIS by the 5th of every month.

Quality Control
Cumulative reports were compiled and presented to District Health Management Team (DHMT) for approval; after the endorsement by DHMT district reports were submitted to central level HMIS. All oedema cases detected were verified by a senior HSAs, a district nutritionists and a UNICEF field monitor.

Micronutrient Interventions
To address micronutrient deficiency disorders, UNICEF supported micronutrient interventions for children 6-59 months through biannual child health days conducted in March 2016 (round 1) and November (Round2) 2016. During the first round, 1,224,006 boys and 1,391,631 girls were reached with vitamin A supplementation, some 97 per cent coverage of those targeted. The target for de-worming children aged 12-59 months was also achieved during round 1 with 1,154,084 boys and 1,273,989 girls reached.

Data Management
Tally sheets for children aged 6 to 59 months, who were screened for malnutrition, were summarised in the health surveillance assistant (HSA) monthly reports. The data was summarised and broken down by catchment area before being submitted to health facilities, and from there to the local district office, after consolidation into a facility summary report. The reports were reviewed before being sent to local district HMIS by the 5th of every month.

Quality Control
Cumulative reports were compiled and presented to District Health Management Team (DHMT) for approval; after the endorsement by DHMT district reports were submitted to central level HMIS. All oedema cases detected were verified by a senior HSAs, a district nutritionists and a UNICEF field monitor.
UNICEF built and upheld strategic relationships with other agencies and clusters throughout the emergency response period to minimize duplication and ensure good coordination among stakeholders. The Nutrition Cluster ensured its participation in the Humanitarian Response Committee, Inter Cluster Coordination fora, and other clusters including Food Security, Protection, WASH, Education and Health. These strategic alliances resulted in high performance of programmatic efforts and ensured coordination and efficiency at both planning and execution stages.

UNICEF implemented programmes in collaboration with WFP and UNAIDS to ensure interventions were robust and addressed the needs of the most vulnerable. Adolescents, women and children affected by the emergency were reached through joint resource mobilization, implementation activities and monitoring.
During the drought emergency, UNICEF supported the government in conducting three comprehensive SMART (Standardized Monitoring and Assessment of Relief and Transitions) nutrition surveys. The results of the surveys played a critical role in assessing the situation, prioritizing actions and achieving high quality results. Additionally, UNICEF worked to build capacity among government partner agencies and academia to ensure the survey were carried out using the correct methodology. This resulted in implementation of quality surveys in seven livelihood zones, provided disaggregated data for targeting and scale up of CMAM services, and informed resource mobilization. As a result of in-depth training, optimal supervision, daily data entry and plausibility checks, and daily debriefing meeting, the overall quality of the SMART Surveys was excellent.
UNICEF ensured a vigorous pipeline of lifesaving nutrition commodities was maintained throughout the emergency response. The monthly distribution plans were prepared based on CMAM data and supply monitoring. Tracking reports were received from each district on a weekly basis. Nutrition field monitors conducted weekly stock status monitoring and required re-stocking, which resulted in few stock shortages in CMAM sites across all 28 districts.

UNICEF established partnerships with seven key NGOs including World Vision Malawi, Plan Malawi, Concern Universal, Concern Worldwide, Save the Children, JHPIEGO and World Relief to support the nutrition emergency response. In addition, UNICEF established a partnership with the Story Workshop Educational Trust (SWET) to work on C4D related activities and help mobilise communities for mass screening and case detection.

PARTNERSHIP AT EXECUTION LEVEL

UNICEF ensured a vigorous pipeline of lifesaving nutrition commodities was maintained throughout the emergency response. The monthly distribution plans were prepared based on CMAM data and supply monitoring. Tracking reports were received from each district on a weekly basis. Nutrition field monitors conducted weekly stock status monitoring and required re-stocking, which resulted in few stock shortages in CMAM sites across all 28 districts.

SUPPLY CHAIN MANAGEMENT
UNICEF took lead and worked collaboratively with other nutrition stakeholders to mobilize the resources for Nutrition Cluster response plan.

Several joint proposals were developed by UNICEF, WFP and UNAIDS, and were funded adequately. Under the leadership of UNICEF, the Nutrition Cluster was able to make use of 93 per cent funding during the first phase from October, 2015, to April, 2016, and 100 per cent funds during the second phase from July, 2016, to March, 2017.

For both phases of the emergency response, the nutrition cluster required US$38.4 million which was 96.5 per cent funded with cooperation from DFID, the World Bank, USAID, Japan, Swiss Natcom, BMZ, German Natcom and Korean. At the start of the second phase the World Bank provided a grant to the Government of Malawi which was channeled through UNICEF and WFP for the procurement services.

UNICEF consistently developed and shared information on the emergency response through monthly nutrition bulletins; cluster meetings and other humanitarian coordination gatherings. The bulletins were disseminated through email as well a Nutrition Cluster web page, which was managed by UNICEF and accessible to all stakeholders. The regular flow of data and information helped partners align their emergency response.
**Social Protection**

During the emergency, some of the poorest households targeted in the Social Cash Transfer Programme (SCTP) were also affected. While UNICEF strengthened the ties between children identified with acute malnutrition and SCTP, gaps were identified when it came to providing a social safety net for vulnerable households. However, after strong advocacy efforts supported by UNICEF, a decision was made to include children under five years with acute malnutrition in future food insecurity responses. As the children had been classified as a vulnerable group, in future the households of these children will have a safety net as they will be assisted through food and cash responses.

**HIV and AIDS**

Malawi’s integration model on nutrition and HIV in CMAM has been held up as good model for other countries. During the emergency response, HIV services were integrated at community level and included identification of HIV exposed babies, counselling mothers on exclusive breastfeeding and referral to health facilities for mothers who opt not to breastfeed. Furthermore, HIV positive lactating mothers were counselled on prevention of mother to child transmission of HIV during the lactation period. Communication campaigns tailored to the local context were also implemented to promote optimal infant and young child feeding practices among HIV positive mothers.

**Communication for Development (C4D)**

Several C4D interventions were implemented in order to promote malnutrition case detection and help change key behaviours for the prevention of malnutrition. For example, UNICEF implemented mass media campaigns, which included promotional jingles and public service announcements. They reached 90 per cent of the country and aired every day of the week. The media campaigns reached an estimated audience of over five million people in all the affected districts and throughout the country. UNICEF also established a partnership with the Malawi Institute of Journalism to monitor the implementation of media based interventions. As a first step, they conducted a baseline assessment, which found a lack of knowledge on proper nutrition practices among the population. The findings were integrated into different radio formats by media outlets to prioritize and address the most pressing issues related to prevention of malnutrition, as well as trigger action at household and community levels.

At the same time, a partnership with Centre for Development Communications (CDC), that involved 71 community dialogue sessions facilitated using community cinema, a total of 51,983 community members were reached. And through a partnership with Story Workshop Educational Trust (SWET) an estimated 210,781 people were reached through participatory theatre for development, facilitated community dialogues and cultural festivals in 16 food insecure districts. A total of 375 HSAs helped to strengthen monitoring and evaluation of C4D interventions to ensure quality of results at community and household levels. As a result of all of these efforts, thousands of people were motivated to seek early help in health facilities for their children. They were also able to recognize the signs and symptoms of acute malnutrition and to know how to prevent malnutrition among their children.
In Malawi, UNICEF’s overall goal when it comes to combating malnutrition is to ensure that at least 60 per cent of children under five years of age have equitable access to, and use of, quality promotive, preventive and curative nutritional services by 2018. UNICEF supports the implementation of high impact evidenced based nutrition specific interventions with a strong focus on prevention of stunting. Using a life-cycle approach, these interventions include provision of maternal iron/folate supplementation, breastfeeding promotion and support, promotion of age appropriate complementary feeding, Vitamin A supplementation in children 6-59 months, de-worming, consumption of micronutrient fortified foods and the treatment of children with acute malnutrition. UNICEF’s nutrition programming staff should also work with other sectors including Health, Agriculture, WASH, HIV and Education to implement multi-sectoral, high impact interventions that address the underlying causes of malnutrition.
UNICEF will work on the following areas to strengthen its child-centered resilience approach:

**Strengthen Infant and Young Child Feeding (IYCF) Programme**
IYCF is a key component to child survival, nutrition, health, growth and development. It also helps prevent of childhood obesity and disease. UNICEF Malawi aims to strengthen IYCF through one-on-one peer-to-peer counselling and group counselling. Community based HSAs will be trained in community IYCF using the UNICEF generic IYCF training package to facilitate IYCF support groups, conduct action oriented sessions on IYCF and provide individual IYCF counselling. In addition, care groups will be established using the harmonized care group package (SUN-NECS) developed by DNHA.

**Active Case Identification through CCGs and C-IMCI**
A CMAM bottleneck analysis undertaken in 2014 by the MoH, in collaboration with partners, revealed low overall CMAM coverage across the country. To address this issue, UNICEF is helping to strengthen the health system to ensure effective, quality services delivery at community and facilities level. One of the key issues communities encounter is the timely identification and referral of acutely malnourished children for appropriate treatment, which will be tackled through community based mechanisms.

**CMAM Capacity Building**
With the rollout of updated CMAM guidelines, UNICEF is helping to train health care providers on new protocols, across the country. Additionally, UNICEF will continue to provide mentorship, support and supervision of health workers in NRUs, OTPs and SFPs, ensuring quality treatment in accordance with the national guidelines. UNICEF will support the nutrition unit in MoH in the establishment of centers of excellence for treatment of SAM in all five health zones in Malawi.

**Strengthening the Surveillance**
To maximize the community resilience, UNICEF aims to support DNHA, strengthening its processes through improved community nutrition surveillance and the establishment of a community based nutrition information system.

**Supplies Integration**
Under the leadership of the Nutrition Unit in the MoH, UNICEF Malawi will support an effort to integrate nutrition supplies into the MoH’s supply chain. Integration of nutrition commodities, warehousing and distribution of essential drugs supplies will be more efficient and lower costs. As described by UNICEF Malawi’s work plan, by December, 2018, nutrition supplies will be integrated into the MoH’s supplies delivery system. Additionally, therapeutic nutrition commodities will be integrated into the MoH’s logistics management information system, which will increase accountability and oversight at the facility level.

**Building Nutritionally Resilient Communities Through Life Cycle Approach**
UNICEF Malawi’s policies for combating malnutrition aim to adopt a lifecycle approach by targeting young children, through existing Early Childhood Development (ECD) programming. Adolescent girls will also be targeted in schools and village clinics. Awareness raising on the importance of micronutrient supplementation for pregnant women and adolescent girls will be undertaken using interactive community radio programmes, theatre for development, and increasing integration with antenatal care programming. At the same time, UNICEF aims to deliver messages that promote early uptake of antenatal care and maternal nutrition services.

**Strengthened Monitoring and Evaluation Systems**
UNICEF has invested in monitoring and evaluation of nutrition programming to support the DNHA and the MoH. UNICEF has so far contributed to the revision of DHIS-2 indicators, the launch of Rapid-Pro SMS base monitoring system, and provided continued support to the MoH’s Nutrition Data Unit. To more efficiently steer nutrition programming, more emphasis will be put on improving data quality, analysing performance indicators and undertaking regular surveys, reviews and evaluations. Additionally, UNICEF will support and invest in community based monitoring systems.
EXPRESSION OF THANKS

“UNICEF would like thank its donors for their support. Your assistance helped us reach children who were in a critical situation, facing life-threatening conditions. Together we saved lives and implemented programmes that had a positive impact on child health and wellbeing. Our interventions will continue to make a difference as these children grow up. Their chances of having successful, productive lives have greatly improved.”
Story of Mphatso

At the hospital, Mphatso was immediately admitted for treatment. He was given antibiotics to treat high fever and was provided with special milk designed to treat severe acute malnutrition. Within ten days Mphatso had greatly improved. “After that he rarely cried, he had an appetite and had gained weight,” says Caroline. Mphatso was later discharged from the impatient program to continue treatment in an outpatient program. He was provided with ready to use therapeutic food (RUTF), a peanut butter paste high in nutrients and energy. Caroline was advised on when to feed Mphatso and to visit the facility once a week to get more RUTF. After month in the outpatient program, Mphatso was much better. His weight increased to 7 kilograms.

Mphatso is one of the many children in Malawi who might have lost their lives if not for the support of UNICEF and its partners. UNICEF supports the Government of Malawi through the Ministry of Health in treating children with malnutrition by procuring and distributing nutrition supplies in the form of therapeutic foods and milk.
Ellen Steven of Kampioni Village, Traditional Authority Chap-ananga in Chikwawa district is one of the many children affected by the hunger crisis in Chikwawa; she was diagnosed with Severe Acute Malnutrition condition. According to Ellen’s mother, Susan, it all started when Ellen started feeling ill as she was refusing to eat. “My child had no appetite for some days and I noticed that she was getting weak,” says Susan, adding, “I rushed to Gaga Health Centre where she was diagnosed with malnutrition. Following this she was put on Ready to Use Therapeutic Food (RUTF) treatment, which she was taking at home ”narrated Susan. However, Ellen’s condition worsened as within two weeks of RUTF treatment, she started swelling in the feet all the way to arms, a medical condition known as oedema. Ellen’s condition deteriorated further as she developed sores on the feet and the neck. Sensing danger, Ellen was referred to Chikwawa Nutrition Rehabilitation Unit (NRU) for in-patient treatment. According to John Mugawa, Chikwawa District Nutrition Coordinator and a Clinician in the NRU, Ellen is one of the worst malnutrition cases to handle at the facility.

“Normally we treat malnutrition cases for a week or so and discharge; but Ellen spent more than 3 weeks in the NRU. This is how dangerous the situation was, we could have lost the child the good thing is that we had adequate stocks of all therapeutic supplies for treatment of severe acute malnutrition, thanks to our relationship with UNICEF. We managed to save her life,” said Mugawa. Following a successful NRU treatment, Ellen was discharged and continued with RUTF treatment as per outpatient treatment protocol at Gaga Health Centre. Ellen responded well to the treatment and in six weeks of treatment, was certified cured of severe acute malnutrition and discharged.

Now, Susan and her family are all smiles as she comments, “I never thought my child would be alive by now. It was a hopeless situation. I thank all the medical personnel at Gaga Health Centre and Chikwawa NRU for their efforts in saving the life of my child;” narrated Susan while looking at her child in admiration.

Inspired by how medical personnel helped in saving Ellen’s life, Susan’s dream for her child is to become a medical doctor to assist in saving other people’s lives.

Ellen’s case is a story of many children whose life’s aspiration are threatened by malnutrition in many communities. In Chikwawa during January to July 2016 a total of 5,664 children received lifesaving treatment support for Severe and Moderate Acute Malnutrition conditions.
In June 2016, at the peak of the hunger crisis, I visited Chikwawa district as part of a team that was documenting the effects of the crisis on children. The journey took us to Dolo Health Centre where a nutrition clinic was in session. Attending the clinic were many mothers who had brought their children for a malnutrition check-up and treatment. What I saw that day shocked me. There were many children who had signs of malnutrition, but one little girl stood out from the rest. Dressed in a tattered light blue dress, she lay on a cloth wrapper under the shade, looking very frail. I could see the pain on her face as she writhed around. She had sores all over her body. She couldn’t sit by herself due to diarrhoea that had lasted months. This was Konja at 12 months. Konja came to Dolo Health centre with her grandmother Jolita Dezmata, a peasant farmer grappling with the hunger crisis. Jolita had walked almost nine km to the health centre to seek treatment for her grandchild. The love of the grandmother, showed me how much she wanted Konja to live. I talked to Jolita about the little girl. She told me that Konja’s mum was young and expecting her fourth child at the time. The hunger crisis meant Konja and her siblings were not getting enough food. The severity of Konja’s situation was what drove her to seek for medical help. Her situation was so critical that the medical staff at Dolo health centre referred her to the Nchalo Nutrition Rehabilitation Unit. This is the procedure for children who are malnourished and suffering from other medical complications – to ensure that they get close medical attention as they recover. Konja stayed in the rehabilitation unit for over a week receiving medication and therapeutic foods. Since the day I met her, Konja has been on my mind and we have been following up with her grandmother. I revisited her in October. What I saw was a different girl to the one we saw in June. Konja was smiling, playing and able to sit on her own. She was bubbly and happy. I could hardly believe she was the same child. As I look back on how we met Konja in early June, I can’t stop thinking of what could have happened to her. If it weren’t for UNICEF’s support to the district health office nutrition, funding the therapeutic milks and ready to use therapeutic food that saved her life, Konja’s story would not have had this happy ending.
ANNEX 4
Current Scaled Up CMAM Program Coverage

CMAM Services distribution by health facilities as of January 2018

KEY
- NRU/SFP
- OTP
- OTP/NRU
- OTP/NRU/SFP
- OTP/SFP
- SFP
SAM cases admitted by district in 2017
MAM cases admitted by district in 2017

MALAWI

KEY

- <50%
- 50% - 60%
- 60% - 80%
- >80%
SAM cure rates by district in 2017

**KEY**
- <80%
- 80% - 90%
- >90%
MAM cure rates by district in 2017

**KEY**
- <80%
- 80% - 90%
- >90%
SAM death rates by district in 2017

KEY
- 0% - 1%
- 1% - 3%
- 3% - 5%
- >5%