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for every child

HEALTH
HIV AND AIDS
WATER, SANITATION AND HYGIENE
NUTRITION
EDUCATION
CHILD PROTECTION
SOCIAL INCLUSION
GENDER EQUALITY
HUMANITARIAN ACTION

Annual Results Report 2017

Nutrition

UNICEF's Strategic Plan 2014–2017 guides the organization's work in support of the realization of the rights of every child. At the core of the Strategic Plan, UNICEF's equity strategy – which emphasizes reaching the most disadvantaged and excluded children, caregivers and families – translates this commitment to children's rights into action.

The following report summarizes how UNICEF and its partners contributed to nutrition in 2017 and reviews the impact of these accomplishments on children and the communities where they live. This is one of nine reports on the results of efforts during the past year, encompassing gender equality and humanitarian action as well as each of the seven Strategic Plan outcome areas – health, HIV and AIDS, WASH, nutrition, education, child protection and social inclusion. It complements the 2017 Executive Director Annual Report (EDAR), UNICEF's official accountability document for the past year.

Marciana Do Santos brings her baby daughter Alifa for nutritional screening at an integrated community health service post in Balibo, Bobonaro municipality, Timor-Leste.

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EXECUTIVE SUMMARY

Well-nourished children are the foundation of thriving communities and nations. With good nutrition, children develop into healthy, bright and engaged members of their communities; and they are stronger and more resilient in the face of crisis. Together with their families and communities, well-nourished children are the architects of a sustainable and prosperous future.

Global momentum for improving nutrition continued to grow in 2017, and countries made important strides in scaling up nutrition programmes in pursuit of the Sustainable Development Goals (SDGs), including Goal 2 to end hunger and all forms of malnutrition by 2030. Over the past four years, exclusive breastfeeding rates have risen, and counselling to improve infant and young child feeding practices has expanded to reach more communities in need. In places where nutritious diets are out of reach, point-of-use fortification programmes are protecting more children than ever before from the ravages of anaemia and other nutrient deficiencies. Today, children facing hunger and malnutrition have greater access to life-saving treatment and care than four years ago, and global partners have joined forces to urgently close the gap on those still being left behind.

A future without malnutrition is within our grasp – but faster progress is still needed to achieve the targets of the ambitious 2030 Agenda for Sustainable Development. Nearly every country in the world is still facing enduring challenges in guaranteeing nutritious, age-appropriate and safe diets for all children. Today, there are still 50 million young lives at risk due to acute malnutrition; and 156 million more children under the age of 5 years are chronically undernourished or stunted, compromising their physical growth and brain development. In rich and poor countries alike, the rise of overweight and obesity – affecting 42 million children under 5 years of age – is presenting a different but equally serious public health problem.

UNICEF continued to address these pressing concerns in 2017, with programmes in emergency and non-emergency contexts that aimed to prevent all forms of malnutrition and save lives where preventive measures fell short. This work was supported by 559 technical staff members across nutrition programmes in 120 countries, particularly those with the highest burdens of malnutrition, including in East Asia and the Pacific, Eastern and Southern Africa, South Asia, and West and Central Africa.

UNICEF work and results in 2017

In the final year of the UNICEF Strategic Plan, 2014–2017, the organization made significant progress globally towards achieving Outcome 4 – t*he improved and equitable use of nutritional support and improved nutrition and care practices*. Results are reported under four nutrition programme areas: (1) infant and young child nutrition; (2) micronutrient supplementation and food fortification; (3) treatment and care of children with severe acute malnutrition and nutrition in emergencies; and (4) general nutrition. Financial resources to support nutrition work grew steadily throughout the UNICEF Strategic Plan, 2014–2017, from US$484 million in 2014 to US$665 million in 2017.

In the **infant and young child nutrition** programme area, UNICEF continued to support the scale-up of community-based counselling services to improve caregivers' knowledge of and skills in optimal feeding practices. The number of countries with the capacity to provide infant and young child feeding counselling services to communities increased steadily, from 105 in 2014 to 115 in 2017.

With the scale-up of infant and young child nutrition programmes over the past four years, the number of countries with exclusive breastfeeding rates above 50 per cent increased from 27 in 2014 to 35 in 2017. During the same period, the number of countries with minimum diet diversity rates above 30 per cent in children aged 6–23 months increased from 20 to 27.

UNICEF and its partners also sparked important advancements in the global landscape of infant and young child nutrition as a result of concerted and strategic advocacy in 2017. The Global Breastfeeding Collective, a partnership led by UNICEF and the World Health Organization (WHO), released an investment case on breastfeeding and a global breastfeeding scorecard to track global and country progress against seven key policy recommendations for improving rates of breastfeeding. These initiatives generated significant media coverage in top-tier media outlets (at least 2,000 print, online and broadcast media in six languages) and, together with UNICEF's World Breastfeeding Week posts, reached an estimated 545 million people via social media,[1] with active engagement by more than 190,000.

UNICEF provided technical support to governments to fully implement the International Code of Marketing of Breast-milk Substitutes through the adoption, monitoring and enforcement of national legislation. Guidance was provided to the governments of Kenya, the Lao People's Democratic Republic, Lesotho, Mongolia, the Niger, Pakistan, the Philippines, Somalia, Timor-Leste and Zambia in 2017; with this support there are now 136 countries with at least some form of legal measure in place covering some or all the provisions of the Code.

In the **micronutrient supplementation and fortification** programme area, UNICEF convened or served leadership roles on the boards of seven key global micronutrient partnerships, generating evidence to inform policy and providing global guidance.

A young child enjoys a nutritious lunch at Baan Wanaluang School in the northern Mae Hong Son Province, Thailand.

During the first three years of the strategic plan, at least 250 million children in need were reached with two doses of vitamin A supplementation each year, providing them with life-saving protection against the consequences of vitamin A deficiency. In collaboration with Nutrition International, UNICEF supplied approximately 553 million vitamin A capsules to 58 priority countries in 2017, contributing to an increase in the number of countries with sufficient supply to provide vitamin A supplementation to all children in need, from 61 in 2016 to 70 in 2017.

The number of countries implementing point-of-use fortification programmes, where caregivers add multiple micronutrient powders (MNPs) to fortify foods for young children, have increased steadily throughout the strategic plan period to reach 62 countries worldwide. More than 15.6 million children received MNPs to prevent anaemia and micronutrient deficiencies – three times the number reached in 2014. With UNICEF support, governments are also strengthening frameworks for addressing anaemia in women and girls of reproductive age; the number of countries with a policy or plan on anaemia reduction increased from 79 in 2016, to 91 in 2017.

With the support of UNICEF and the Iodine Global Network over the past four years, the world moved a step closer to eliminating iodine deficiency. In 2017, more than 86 per cent of households globally consumed iodized salt; and there are now 27 countries where at least 90 per cent of households are consuming iodized salt, an increase from 25 the previous year, surpassing the strategic plan target.

In the programme area of **treatment and care for children with severe acute malnutrition and nutrition in emergencies**, UNICEF supported the scale-up of treatment and care for children with severe acute malnutrition in 67 countries in 2017, reaching children living in both development and emergency contexts. The annual number of children who received life-saving treatment and care increased from 3.2 million in 2014 to 4 million in 2017, achieving the strategic plan target. In total, over the four-year strategic plan period, more than 14.9 million children with severe acute malnutrition were treated in all contexts. In the context of emergency nutrition response, 3 million children were treated in 2017, with 91 per cent of them recovering.

In the wake of complex humanitarian crises throughout 2017, UNICEF provided critical support to improve emergency preparedness and response in 66 countries. UNICEF supports governments in developing risk-informed programmes that are poised to adapt when emergencies strike. There are now more countries putting the right policies and strategies in place ahead of time and securing the human resources needed to scale up emergency response when needed. By 2017, there were 65 countries with an emergency/risk management strategy incorporated within their nutrition plan or policy, compared with 56 countries in 2014.

UNICEF is mandated as the Cluster Lead Agency for Nutrition, working to promote coordinated, timely and effective nutrition emergency response at national and subnational levels. In countries where the nutrition cluster was activated, UNICEF led and engaged partners, ensured that coordination mechanisms were established and supported, and served as the first point of contact for the government and as a provider of last resort. In 2017, UNICEF supported coordination for nutrition in emergencies in 58 countries. As part of the Global Nutrition Cluster, UNICEF and its more than 40 partners supported the coordination of emergency nutrition services for more than 517 million people in need globally.

During emergencies, caregivers face important challenges in providing safe and adequate food for children, and governments need guidance and technical assistance to address these pressing issues. UNICEF and the Emergency Nutrition Network co-led the update of the Infant Feeding in Emergencies Operational Guidance in 2017, disseminating this guidance to 100 countries in preparation for further scale-up in 2018. UNICEF also developed guidance for the procurement and use of breastmilk substitutes during humanitarian crises, in an effort to regulate the uncontrolled and unethical distribution of infant formula during emergencies, while providing support for infants with no option to be breastfed.

In the **general nutrition** programme area, UNICEF continued to support countries in strengthening national policies and frameworks for maternal and child nutrition. The number of countries with a nutrition sector policy or plan developed or revised with UNICEF support increased four-fold over the strategic plan period, from 22 countries in 2014 to 94 countries in 2017.

Partnerships are critical to galvanizing action for maternal and child nutrition. In 2017, UNICEF remained the chair, a coordination committee member or a board member of 12 global nutrition initiatives, exceeding the target of 10. Globally, in 2017, UNICEF staff authored or co-authored 75 peer-reviewed articles across the sector, exceeding the target of 50 products per year. This work has made a critical contribution to the global evidence base and positioned UNICEF as a leader in maternal and child nutrition.

Given that nutritional status is influenced heavily by behavioural and social factors, UNICEF supports the application of Communication for Development (C4D), which employs a mix of communication tools and approaches to foster positive change in caregiver and community attitudes and practices. UNICEF strengthened its capacities for supporting governments and partners in planning and coordinating C4D activities in 2017 by placing C4D advisors in regional offices to provide additional technical support.

Looking ahead

There are a number of important challenges to be addressed over the next four years as UNICEF transitions to its Strategic Plan, 2018–2021. As the scale and complexity of nutrition emergencies continue to increase, flexible funding streams are urgently needed to engage in systems strengthening, invest more strategically in prevention, and leverage an increasing number of platforms to deliver results for the most vulnerable children, no matter where they live.

Years of experience have shown that to achieve scale-up, community programmes must be fully mainstreamed into existing national systems. A system strengthening approach will therefore be critical to reaching the most disadvantaged children who would otherwise have difficulty accessing nutrition services. This is particularly true today in the context protracted emergencies, where greater coherency between humanitarian and development programming will be critical to managing risks, reducing vulnerabilities and strengthening community resilience.

UNICEF will continue investing in innovations, such as real-time reporting mechanisms, to identify places where progress is lagging and to tailor programmes to reach the children most in need. Improved linkages between nutrition, health, water and sanitation, and early childhood development will be vital to achieving results in the next strategic plan period and will also drive progress towards achievement of the 2030 Agenda for Sustainable Development.

STRATEGIC CONTEXT OF 2017

Global trends in malnutrition

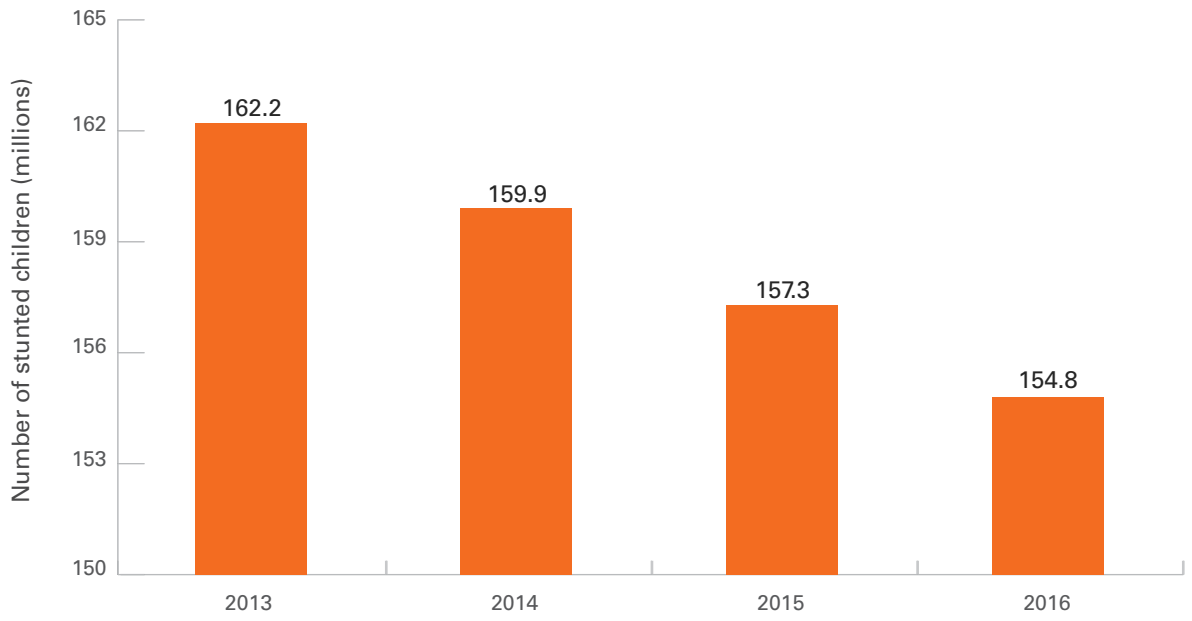
The world has made significant progress in improving nutrition over the past decade. Globally, there were fewer children under 5 years of age suffering from stunting in 2017 than ever before. Indeed, stunting has declined by almost 2 per cent annually over the last four years, affecting 7.7 million fewer children in 2016 than in 2013 (*see Figure 1*).

Despite this progress, 155 million children worldwide have stunted growth, meaning they may never grow to their full height and their brains may never develop to their full cognitive potential.[2] In contrast to global trends, the number of stunted children in Africa is rising due to the slow decline in the prevalence of stunting combined with rapid population growth (*see Figure 2*). There are also 52 million children suffering from wasting, leaving them dangerously thin and at higher risk of death. In South Asia, the prevalence of wasting is so severe – at 16 per cent – that it constitutes a public health emergency (*see Figure 3*).[3]

At the same time, there are 41 million overweight children globally, and no progress has been made to stem these rates in more than 15 years. Indeed, in Africa and Asia, the number of overweight children is on the rise, and, overall, rates have increased most in lower-middle-income countries.[3] Many countries are facing a devastating triple burden of malnutrition – with coexisting burdens of stunting and wasting; vitamin and nutrient deficiencies; and overweight and obesity. This triple burden can be seen at the population level, within communities, within households and even within the same individual. UNICEF and its partners are increasingly using the language of 'all forms of malnutrition' to recognize this complex and interconnected relationship.

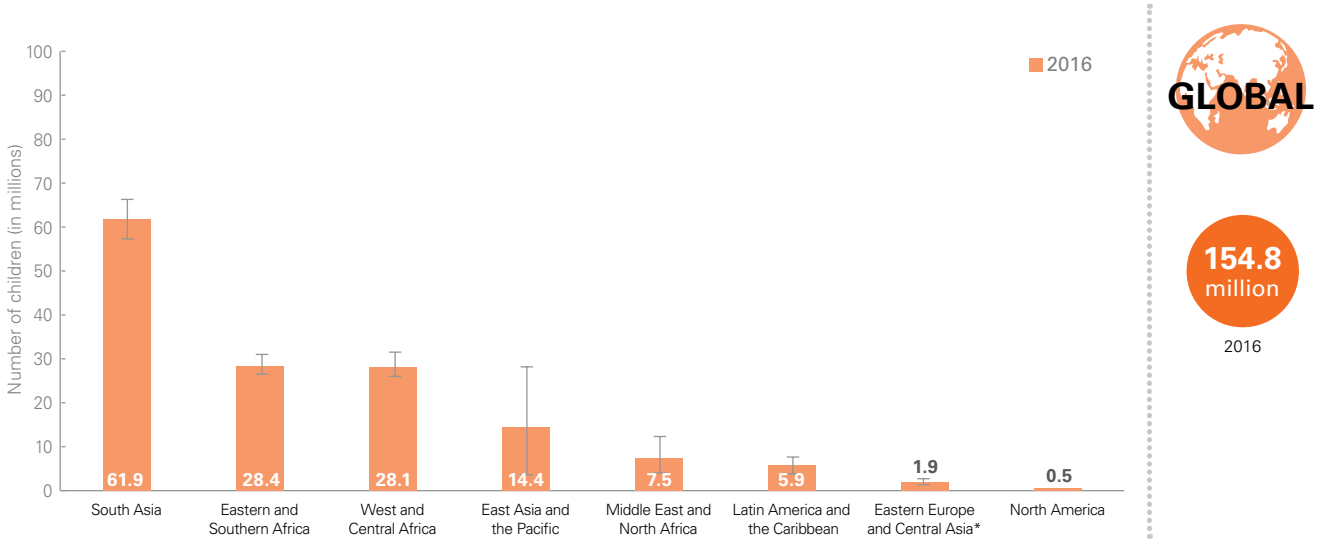
While malnutrition manifests in multiple ways, the most evidence-based and cost-effective solutions for preventing it are already at our fingertips. These include adequate maternal nutrition before and during pregnancy and lactation to ensure adequate weight gain during pregnancy, prevent low birth weight and ensure successful breastfeeding; adequate breastfeeding in the first two years of life, including early initiation within one hour of birth, exclusive breastfeeding in the first six months and continued breastfeeding until 2 years of age; age-appropriate, nutritious and safe foods, and responsive and hygienic feeding practices; and stimulating play and interaction in early childhood. Where nutritious diets are out of reach, micronutrient supplementation and deworming

FIGURE 1: Trends in the numbers of stunted children under 5 years of age, globally, 2013–2016



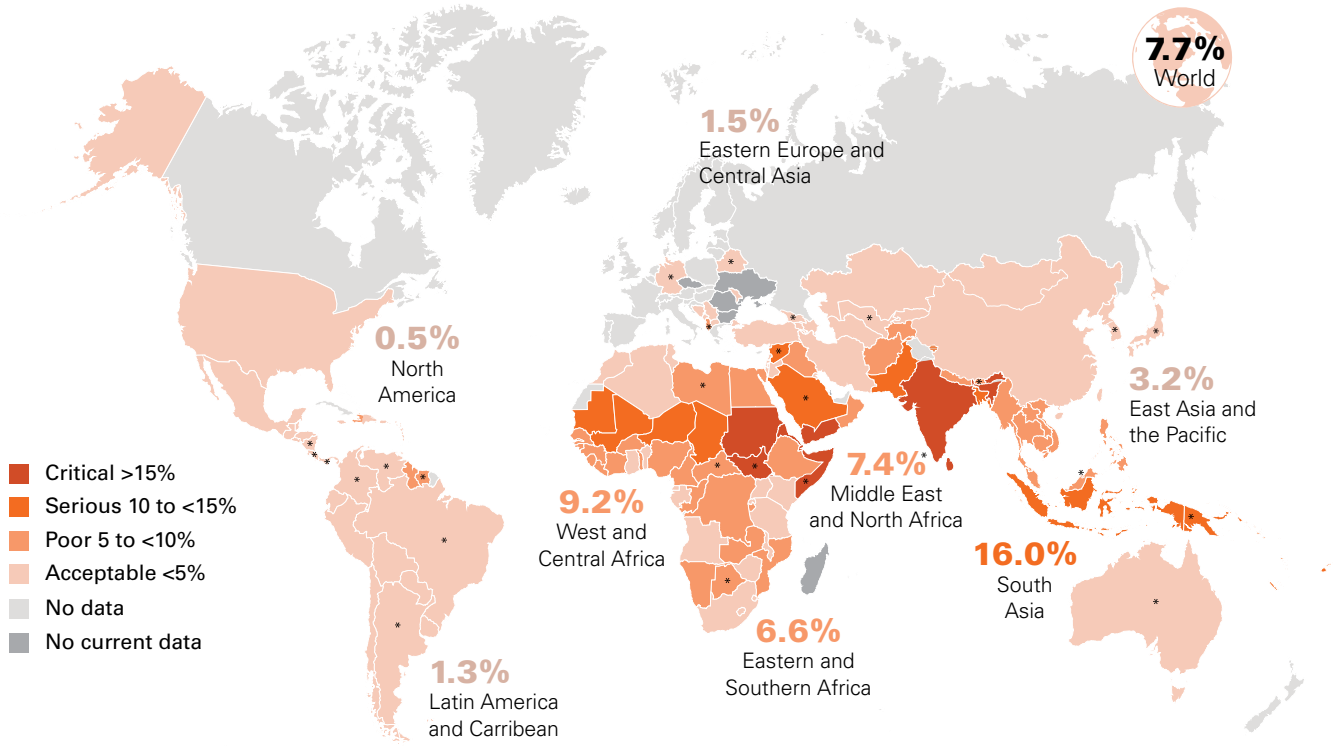
Source: Joint Malnutrition Estimates, 2017 edition. Estimates from 2018 edition are available at https://data.unicef.org/resources/jme/.

FIGURE 2: Number of children under 5 years of age who are stunted, by region, 2016



Source: Joint Malnutrition Estimates, 2017 edition. Estimates from 2018 edition are available at https://data.unicef.org/resources/jme/.
*Note: *Estimates for Eastern Europe and Central Asia are based on a model fit for all of Europe and Central Asia, but for which data were mainly from Eastern Europe and Central Asia. The estimates are thus not shown for Europe and Central Asia, only being displayed for Eastern Europe and Central Asia. North America estimate based on United States data only.*

FIGURE 3: Percentage of children under 5 years of age who are wasted, by region, 2016



Source: Joint Malnutrition Estimates, 2017 edition. Estimates from the 2018 edition are available at: https://data.unicef.org/resources/jme/
Note: Country data are the most recent available estimates between 2011 and 2016; exceptions where older data (2005-2010) are shown are denoted with an asterisk(*) and where only data prior to 2005 are available the dark grey color denoting no recent data is used. Eastern Europe and Central Asia region does not include Russian Federation due to missing data; consecutive low population coverage for the 2017 estimate (interpret with caution). There is no estimate available for the Europe and Central Asia region or the Western Europe sub-region. North America regional average based on United States data only.

prophylaxis can prevent anaemia and micronutrient deficiencies, and food fortification with essential vitamins and minerals can enrich foods for children and the general population.

These investments in nutrition aimed at improving food, feeding and care practices, combined with access to basic services and a healthy environment, have the power to stop malnutrition before it starts and secure a brighter future for children and their families.

The evolving nutrition landscape in 2017

The global nutrition landscape of 2017 is vastly different from the one four years earlier. The world is on its way to tackling the ambitious Sustainable Development Goals (SDGs), including SDG 2, which aims to end hunger and all forms of malnutrition by 2030. The United Nations' Decade of Action for Nutrition (2016–2025) is now under way, marking a global commitment to support actions to end hunger and malnutrition in all its forms. UNICEF is leading new global partnerships to galvanize action on pressing nutrition challenges, including the Global Breastfeeding Collective, launched in 2017, which aims to increase investments in breastfeeding, and the No Wasted Lives coalition, launched in 2016, which aims to close the alarming gap between the burden of severe acute malnutrition and the number of children being reached with treatment and care. These initiatives and partnerships have shifted the global discourse and built momentum for maternal and child nutrition in 2017 and beyond.

The Scaling Up Nutrition (SUN) movement continued to unite global partners in 2017, with its support for nationally driven efforts to end malnutrition. UNICEF continued to chair the SUN Lead Group and SUN membership expanded steadily throughout the strategic plan period, with the number of country members increasing from 48 in 2014 to 60 countries and 3 states of India in 2017. UNICEF provided support to the SUN global gathering in 2017, bringing together 900 participants from 60 countries, including high-profile leaders. All countries are facing complex nutrition challenges, and the gathering was a chance to review progress and share innovations and best practices to drive progress.

The SUN global gathering coincided with the launch the fourth *Global Nutrition Report*,[4] an independently produced annual stock-take of the state of the world's nutrition. The report argues that ending malnutrition in all its forms will have a profound impact on five core areas of development that run through the SDGs: sustainable food production, infrastructure, health systems, equity and inclusion, and peace and stability. The report calls global stakeholders to action in making nutrition the catalyst for change in the SDG era.

Improving nutrition with equity and sustainability

The world faced increasingly complex emergencies throughout the UNICEF strategic plan period. In 2017, conflict, disasters, displacement and famine ravaged communities in many parts of the world, particularly in north-east Nigeria, Somalia, South Sudan and Yemen. The challenges of migration and climate change have broadened the range of needs and made the delivery of nutrition services more complex and costly.

UNICEF anticipated and responded to these challenging humanitarian situations by strengthening its partnership with members of the Global Nutrition Cluster (GNC), which is composed of more than 40 members working to enable country coordination mechanisms to achieve timely, quality and appropriate nutrition response to emergencies. Together with other cluster members, UNICEF worked to improve its technical and programmatic support to countries to conduct needs assessments, develop emergency nutrition response plans, mobilize human and financial resources, build national capacity, and strengthen the coverage, quality, reach and equity of multisectoral response programmes.

The effectiveness of urgent funding appeals during humanitarian responses enabled UNICEF to reach vulnerable populations in some of the most fragile settings with life-saving services and supplies. Donor funding in emergencies is often heavily weighted towards the treatment of severe acute malnutrition (SAM) and supplies; however, support for breastfeeding and complementary feeding also saves countless lives during emergencies, and investments in these preventive interventions are equally important in both development and humanitarian contexts.

There is an ongoing need for better national nutrition data to inform decision-making. Many countries lack the data to track progress towards nutrition targets,[5] and improving routine data collection is critical to addressing this challenge, and to achieving the SDGs. UNICEF is supporting countries in developing standard data elements for routine monitoring, making them better placed to track progress towards national and global targets. As the gatekeeper of data for children, UNICEF hosts global databases tracking more than 100 nutrition indicators across 202 countries, including disaggregated data on equity that can contribute to vital improvements in programme monitoring.

Investing in nutrition for equity

Investments in nutrition matter. Time and again, evidence shows that nutrition interventions are some of the most cost-effective and high-impact investments for improving global health and welfare.[6]

A mother carries her child to a community clinic for growth monitoring in the Chibolele area, Ndola, Copperbelt Province, Zambia.

For UNICEF, the case for investing in nutrition is even stronger because of its potential for promoting equity. UNICEF deploys resources and services in ways that reach the most vulnerable children first. Indeed, for UNICEF, a programme's ability to achieve equity is a measure of the effective use of resources. With this equity-driven approach, access to high-impact nutrition interventions has improved most rapidly among poor groups in recent years, as shown in the UNICEF report *Narrowing the Gaps: The power of investing in the poorest children*. When investments in nutrition reach the poorest children, they can save nearly twice as many lives as investments in non-poor groups, leading to substantial improvements in equity.[7]

The momentum for scaling up nutrition has grown in recent years, but a significant resource gap remains to meet global targets. A new analysis by the Nutrition for Growth Stakeholders Group[8] calls for an additional investment of US$3.7 billion per year over the Decade of Action to drive progress towards the World Health Assembly targets for stunting, anaemia, exclusive breastfeeding and treatment of severe wasting.[9] These investments have the power to avert 2.6 million child deaths and protect 58 million children from stunting.[10]

Towards a future without malnutrition

The transition from one strategic plan to the next is an opportunity to reflect on challenges and to commit to accelerating progress in areas where change has been slow. In 2017, UNICEF initiated this process by launching a global delivery compact for the prevention of stunting with its offices in headquarters, regions and the 10 countries that are home to about 75 per cent of stunted and wasted children in the world.

The compact is a four-year agreement with time-bound commitments to accelerate results for children in three key areas: (1) improving dietary diversity in early childhood; (2) preventing anaemia and improving the nutrition of adolescent girls and boys; and (3) improving the nutrition of women during pregnancy and lactation. UNICEF has also established a series of global learning compacts with countries (10–25 countries per compact) that have shown leadership and innovation in addressing emerging programmatic areas of importance, including: (1) nutrition of school-age children; (2) preventing overweight and obesity in childhood; (3) making food systems deliver for children; and (4) integrating early detection and treatment of SAM in routine services for children.

The path to achieving the SDGs will be contingent upon the strength of multisectoral actions – particularly between the food, health, education, water and sanitation, and social protection systems. Strengthening alliances and improving inter-sectoral convergence has never been more urgent. This convergence will also support broader systems strengthening, helping countries to sustain development gains and strengthen resilience so that children and their families survive and thrive no matter where they live.

UNICEF's strength as an organization with multisectoral reach, its wide global, regional and country presence, its network of partnerships – that bring financial resources, expertise and the capacity to influence – and its position as a trusted advisor to governments, make it well placed to lead this work. As the world unites in pursuit of the SDGs, UNICEF leadership will guide countries in scaling up nutrition towards a more sustainable and prosperous world for children, youth, adolescents, women and their families.

RESULTS BY PROGRAMME AREA

In the final year of the UNICEF Strategic Plan, 2014–2017, the nutrition programme made significant progress globally in achieving Outcome 4 on improved nutrition. Results are outlined in the sections that follow according to four programme areas: (1) Infant and young child nutrition; (2) Micronutrient supplementation and fortification; (3) Treatment and care for children with severe acute malnutrition and nutrition in emergencies; and (4) General nutrition. Results for nutrition and HIV are integrated into the four programme areas.

The strategic plan results framework sets targets at three levels: outputs, which directly reflect UNICEF contributions; outcomes, which are the results of shared action; and impact, which is a result of the collective action of states with the support of development partners. Grounded in an overall theory of change for improving nutrition,[11] each programme area section describes the inputs, resources and activities that are deployed to achieve specific programme area outputs that lead to overall outcomes, and in turn impact the reduction of stunting in children and the reduction of anaemia in women of reproductive age.[12]

Annual progress on strategic plan indicators is referenced within each programme area. Where possible, cumulative progress over the four-year strategic plan period is also highlighted. Progress on indicators is flagged for the reader throughout (e.g., P4.a.1, P4.a.2) and supported by examples of how results were achieved at country level in 2017. A full table of indicators and results is given in Annex 1. Each programme area section concludes with a discussion of challenges, reflections and future directions.

The results chain, linking resources to outputs and outcomes in the strategic plan, is illustrated by a diagram at the beginning of each programme area section, while recognizing that the relationship between nutrition expenses and results is interconnected across programme areas. For instance, a successful complementary feeding programme would have benefited from investments from the infant, young and child nutrition programme area (e.g., to support facility- and community-based counselling interventions), the micronutrient supplementation and fortification programme area (e.g., for the supply of micronutrient powders for point-of-use fortification) and the general nutrition programme area (e.g., to support broader nutrition policy development).

As outlined in the theory of change,[13] UNICEF uses time-tested, evidence-based implementation strategies to achieve results globally, regionally and in countries. These include capacity development; evidence generation, policy dialogue and advocacy; partnerships; South–South cooperation; promotion of innovation; integration and cross-sectoral linkages; and service delivery. The synergies between these strategies and the results achieved are explored closely in each programme area.

UNICEF implemented a broad range of nutrition programming in 120 countries in 2017, driven by 559 technical staff members located across all regions, but concentrated in those with the highest burdens of malnutrition, including East Asia and the Pacific, Eastern and Southern Africa, South Asia, and West and Central Africa.

A child's height is measured in Umphang district of Tak province, Thailand.

NUTRITION HEADLINE RESULTS

PROGRAMME AREA 1: INFANT AND YOUNG CHILD NUTRITION

Rates of exclusive breastfeeding have risen over the past four years:

- The number of countries with exclusive breastfeeding rates above 50 per cent increased from 27 in 2014 to 35 in 2017 (P4.1).[14]

Governments are strengthening national legislation to protect, promote and support breastfeeding:

- The number of UNICEF programme countries with national legislation reflecting the International Code of Marketing of Breast-milk Substitutes rose from 64 at baseline to 86 countries in 2017, exceeding the target of 85 (P4.c.1).

PROGRAMME AREA 2: MICRONUTRIENT SUPPLEMENTATION AND FORTIFICATION

Point-of-use fortification programmes are reaching more children than ever before:

- More than 15.6 million children were reached with micronutrient powders – three times the number reached in 2014. To support this expanded reach, the procurement of micronutrient powders increased 340 per cent over the strategic plan period, from 346 million sachets in 2014 to 1.185 billion sachets in 2017.

Countries are strengthening their national policies and strategies on anaemia reduction in women:

- There were 91 countries with a policy or plan for anaemia reduction in women of reproductive age in 2017, an increase from 79 in 2016. The number of these countries with a specific approach for tackling anaemia in adolescent girls rose from 41 to 56, exceeding the target of 50 countries (P4.c.2).

The world is moving closer to eliminating iodine deficiency:

- There are now 27 countries where at least 90 per cent of households are consuming iodized salt, an increase from 25 the previous year and exceeding the target (P4.2). Globally, the average household consumption of iodized salt in 2017 reached 86 per cent.

PROGRAMME AREA 3: TREATMENT AND CARE FOR CHILDREN WITH SEVERE ACUTE MALNUTRITION AND NUTRITION IN EMERGENCIES

More children with SAM are receiving treatment and care:

- The annual number of children treated for SAM increased from 3.2 million in 2014 to 4 million in 2017, achieving the strategic plan target (P4.5). In the context of the emergency nutrition response, 3 million children with SAM were treated, with 91 per cent of them recovering (P4.d.1).

Countries are better equipped to respond to nutrition emergencies:

- There are now 65 countries with an emergency/risk management strategy integrated into their nutrition plan or policy, a small increase from 64 in 2016 (P4.c.3).[15]

PROGRAMME AREA 4: GENERAL NUTRITION

UNICEF is leading and supporting an increasing number of global nutrition partnerships:

- In 2017, UNICEF remained chair, coordination committee member or board member of 12 global nutrition initiatives,[16] exceeding the target of 10 (P4.f.2).

UNICEF continues to be a global knowledge leader in maternal and child nutrition:

- UNICEF staff authored or co-authored 75 peer-reviewed articles in 2017, exceeding the target of 50 products per year (P4.f.1).

Programme Area 1: Infant and young child nutrition

NOURISHING A NEW GENERATION

Food and feeding practices in infancy and early childhood have a profound impact on the rest of a child's life. From birth to age 2 years, children who receive the right foods at the right time of their development are more likely to survive, grow, develop, learn and participate fully in their communities.

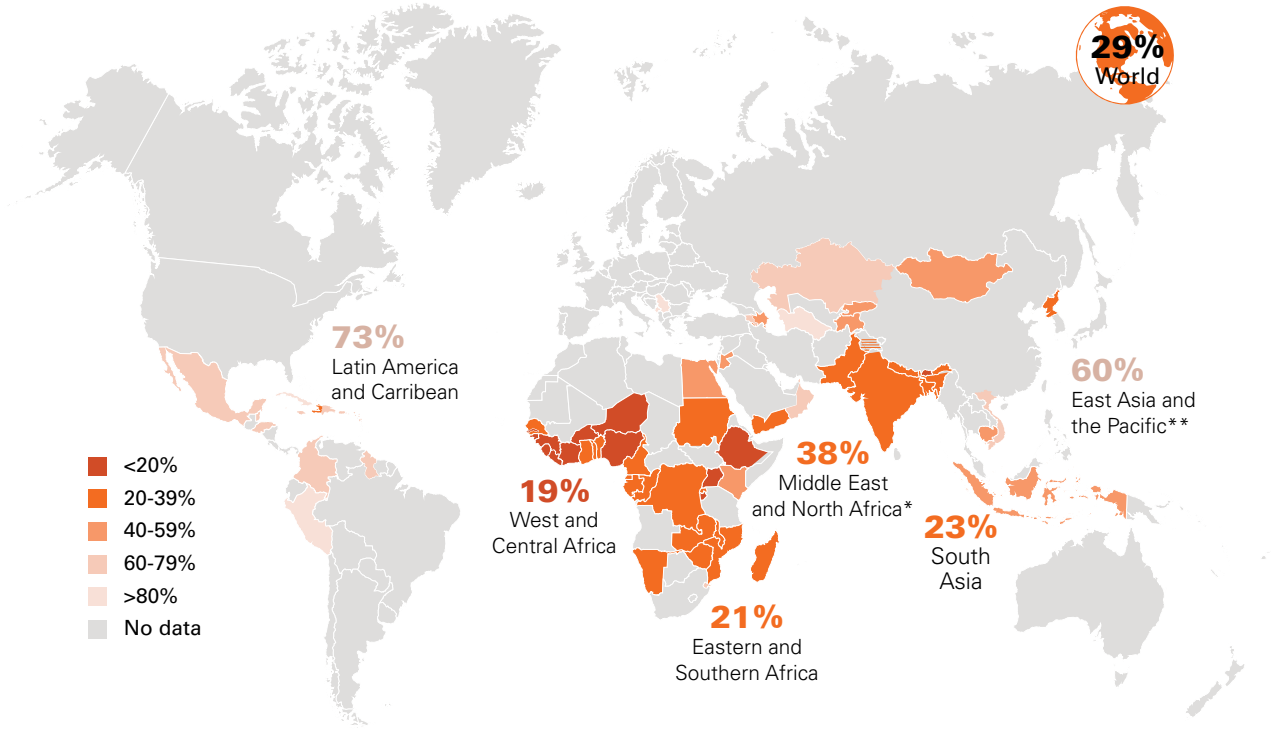
UNICEF and the World Health Organization (WHO) define[17] optimal infant and young child feeding (IYCF) practices as: initiation of breastfeeding within the first hour of life; exclusive breastfeeding for the first six months; and continued breastfeeding until age 2 years or longer. At 6 months of age, children should be introduced to their first solid, semi-solid or soft foods. These first foods, known as 'complementary foods', should be nutritionally adequate, safe and provided in response to a child's needs and hunger signals.

The protection, promotion and support of good IYCF practices are central to preventing all forms of child malnutrition, including stunting, wasting and micronutrient deficiencies, as well as overweight and obesity. Despite these critical benefits, most newborns, infants and young children around the world are not receiving the nutritious diets they need to survive and develop to their full potential. In low- and middle-income countries, only 40 per cent of infants under 6 months old are exclusively breastfed and only 29 per cent of children aged 6–23 months are fed complementary foods that meet the minimum dietary diversity[18] needed for growth and development (*see Figure 4*).[19]

Through its infant and young child nutrition programme, UNICEF supports governments in addressing the policy, economic, social and cultural barriers to providing children with adequate quantities of age-appropriate nutritious and safe foods. UNICEF expands and improves the timeliness and quality of information, education, counselling and support for mothers and caregivers in health facilities and communities; provides guidance on strengthening maternity protection; supports the enactment of national legislation to restrict the promotion of breastmilk substitutes; and advocates for greater political commitment and domestic budget investments in infant and young child nutrition.

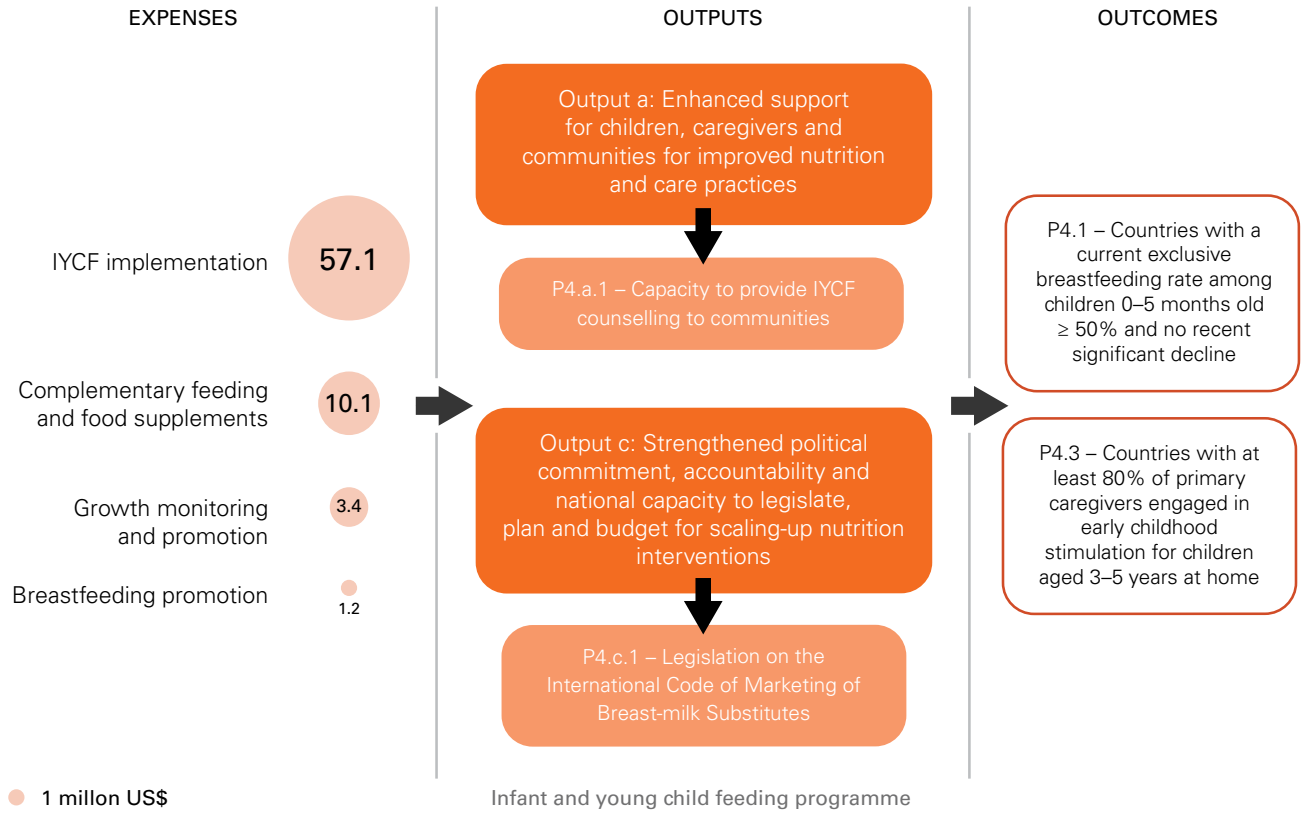
Zar Gyi of North Htan Kone village of Oaktwin Township, Myanmar, breastfeeds her child during break time at the paddy field.

FIGURE 4: Percentage of children 6–23 months of age with the minimum diet diversity, 2015[20]



*Source: UNICEF (2016) From the first hour of life: Making the case for improved infant and young child feeding everywhere. Note: Regional estimates are presented only where adequate population coverage (≥ 50 per cent) is met, *with the exception of Middle East and North Africa, which was based on data covering 46 per cent of the population in that region. **To meet adequate population coverage, East Asia and the Pacific does not include China.*

FIGURE 5: Results chain for infant and young child nutrition



With the support of UNICEF and partners, many countries have made important strides over 2014–2017. The number of countries with exclusive breastfeeding rates above 50 per cent increased from 27 in 2014 to 34 in 2017 (P4.1). Twenty countries[21] increased their exclusive breastfeeding rates by more than 10 percentage points from baseline, including Belize and Myanmar, where exclusive breastfeeding rates nearly doubled. In Burundi, rates increased from 69 per cent in 2011 to 83 per cent in 2017, and Burundi is now one of the top three countries with exclusive breastfeeding rates above 80 per cent, along with Rwanda and Sri Lanka. During the same period, the number of countries with minimum diet diversity rates above 30 per cent in children aged 6–23 months increased from 20 to 27.

RESULTS CHAIN FOR INFANT AND YOUNG CHILD NUTRITION

The results chain for the infant and young child nutrition programme area outlines the linkages between programme spending, key interventions and progress towards the strategic plan output and outcome indicator targets (*see Figure 5*). Full data on the strategic plan indicators are presented in the pages that follow and in Annex 1.

In 2017, US$72 million was spent on the infant and young child nutrition programme area, a decrease from the previous year when the total expenditure was US$83 million. This decline may be explained by an increase in the domestic budgets that were leveraged for IYCF interventions during this period. As in previous years, the largest proportion of funding (US$57 million) was allotted to 'IYCF implementation', which is primarily made up of three types of interventions: systems strengthening, capacity development and service delivery.

OUTPUTS AND RESULTS IN 2017

Improving the quality and availability of community counselling and support

Community-based counselling is a key pillar of strategic infant and young child feeding programmes. Within communities, counselling and support takes various forms: it can be provided to individuals or groups; and it may be facilitated by community workers and/or experienced mothers (known as 'mother-to-mother support groups'). Counselling is tailored to the contexts in which families live, providing concrete actions to change behaviours, improve feeding practices, and strengthen support networks – particularly in settings where the health system is weak.

UNICEF is working to strengthen national capacity to provide community counselling services, which in turn

Zohra feeds her two-year-old daughter some jackfruit seeds inside her makeshift hut in Kutupalong settlement for Rohingya refugees in Ukhiya, a sub-district of Cox's Bazar, Bangladesh.

CASE STUDY 1: NIGERIA: EVALUATING THE IMPACT OF THE UNICEF COMMUNITY COUNSELLING PACKAGE

UNICEF conducted the first evaluation of the community counselling package, in partnership with SPRING and the Federal Ministry of Health, in Nigeria. The evaluation was conducted in Kaduna State in two local government areas (LGAs) that had not previously benefited from IYCF programming: Kajuru LGA served as the intervention site and Kauru LGA served as the comparison site.

The counselling package was implemented over an 18-month period in the intervention LGA and included training for health authorities, health workers and community volunteers, as well as community mobilization and sensitization events, support groups and home visits. Baseline data were collected between December 2014 and June 2015, and end-line data between January and March 2017. The evaluation used a mixed methods approach in intervention and comparison sites, including: qualitative key informant interviews; quantitative assessments of health workers' knowledge and attitudes; quantitative surveys of community leaders' knowledge and attitudes; population-based surveys of pregnant women and mothers of children under 2 years of age; process monitoring; and a costing exercise to assess the scalability of the programme.

The evaluation revealed a significant increase in exclusive breastfeeding rates in the intervention area, from 23 per cent at baseline to 50 per cent at end-line, while in the comparison site exclusive breastfeeding increased from 22 per cent to 35 per cent. The percentage of children born in the last 24 months who were put to the breast within one hour of birth increased by more than 12 percentage points in the intervention site, while it remained constant in the comparison site. The proportion of infants aged 0–5 months who were fed exclusively with breastmilk increased by 28 percentage points in the intervention site, while in the comparison site this proportion improved by only 14 percentage points.

The programme also had a protective effect on the timely introduction of complementary food and meal frequency. While the percentage of infants 6–8 months of age who received solid, semi-solid or soft foods during the previous day remained statistically constant in the intervention site, it declined by 23 percentage points in the comparison site. Similarly, the proportion of breastfed and non-breastfed children 6–23 months of age who received solid, semi-solid or soft food the minimum number of times or more (known as 'minimum meal frequency') remained constant in the intervention site while it declined by 13 percentage points in the comparison site.

In contrast to its clear impact on breastfeeding, counselling did not improve the diversity of children's diets in this context. Although the percentage of women who agreed or strongly agreed with the importance of feeding children a diverse diet was high and increased more in the intervention site than in the comparison site, the percentage of children 6–23 months of age who received food from four or more food groups during the previous day (known as the 'minimum diet diversity') declined in both LGAs, as did the percentage who received a minimum acceptable diet.[22]

This evaluation showed that in some contexts, such as this one in Nigeria, counselling alone is not sufficient to improve dietary diversity in young children. This was due in part to poor food availability, price inflation and fuel shortages, which occurred during the intervention period. The evaluation led to important recommendations for new strategies to protect against such external factors, while addressing social norms and improving women's decision-making power and control of resources. A series of recommendations was also developed for improving planning; funding; expanding reach; training and retraining; supervising, monitoring and mentoring – and these will guide future programmes.

Pregnant and breastfeeding mothers attend an IYCF counselling session facilitated by a community health worker in Mapelele Ward in Mbeya, southern Tanzania.

provide caregivers with the knowledge and skills to improve feeding practices. Overall, there are 115 countries providing IYCF counselling services to communities. Over the four-year strategic plan period, the number of countries with the capacity to provide IYCF counselling services to 70 per cent of communities increased steadily, from 14 countries at baseline to 35 countries in 2017 (P4.a.1).

The UNICEF Community Counselling Package on Infant and Young Child Feeding has been a guiding tool in the provision of community-based counselling since 2000, and more than 50 countries have used some or all of the elements of the package, often adapting them to meet local needs.[23] For the first time since its launch, UNICEF, SPRING (USAID-supported Strengthening Partnerships, Results and Innovations in Nutrition) and the Government of Nigeria embarked on an evaluation of the impact of the counselling package on improving breastfeeding and complementary feeding practices (*see Case Study 1*). In 2017, UNICEF and SPRING also collaborated to expand the package by including a digital image bank and a series of short videos on complementary feeding, including one on counselling, that can be used in training health workers and supporting caregivers.

Many countries have scaled up community counselling and support over the strategic plan period, increasing the number of mothers and caregivers reached with this important intervention (*see Case Study 2*). In Kenya, the number of mothers with newborns receiving counselling on exclusive breastfeeding in six targeted counties increased from around 35,100 in 2016 to more than 81,300 in 2017. To support scale-up and strengthen links with the community primary health care system, UNICEF supported capacity-building training for community health workers, health extension workers and community leaders to improve IYCF practices. These training activities helped establish more than 530 active mother-to-mother support groups in the arid and semi-arid land counties, which helped prevent a deterioration in feeding and care practices during the drought.

Nurturing caregiver–child interactions during feeding are critical to improve brain development in early childhood. A number of countries are making these linkages through IYCF counselling. Combined IYCF and early childhood development (ECD) interventions continue to be important throughout the preschool years and are tracked as an outcome indicator in the strategic plan: by 2017, twenty-six countries were engaging primary caregivers in early childhood stimulation for children aged 3–5 years.

UNICEF supports countries in integrating ECD components such as responsive play, communication and nurturing care within IYCF programmes and policies. In Madagascar, the capacities of more than 11,400 community health and nutrition workers (84 per cent) were strengthened to provide IYCF counselling, an increase from 82 per cent in 2016 and 57 per cent in 2015, and exceeding the planned target of 80 per cent in 2019. UNICEF supported the

CASE STUDY 2: UNITED REPUBLIC OF TANZANIA: SCALING UP IYCF COUNSELLING SERVICES ACROSS COMMUNITIES AND FACILITIES

The scale-up of maternal, adolescent and child nutrition, including IYCF counselling, is a key component of the United Republic of Tanzania's National Multi-Sectoral Nutrition Action Plan (2016–2021) to address childhood stunting.

To increase the availability of nutrition counselling within the five UNICEF-supported regions of the country (Iringa, Mbeya, Njombe, Songwe and Zanzibar), more than 4,000 community health workers were trained to provide IYCF counselling services in more than 2,000 villages. With this increased capacity, the proportion of villages with trained community health workers able to provide IYCF counselling services increased from 15 per cent (460 villages) in 2016 to 64 per cent (1,958 villages) in 2017, demonstrating significant progress towards the target of 75 per cent coverage by 2021.

Equipped with new knowledge and skills, community health workers provided IYCF counselling to more than 300,000 pregnant women and caregivers of children under 2 years, an increase in coverage from 20 per cent in 2016 to 50 per cent in 2017. Men's participation in IYCF counselling groups also increased significantly during this time. These results were achieved by UNICEF in partnership with local government authorities, three national and four international partner non-governmental organizations (NGOs) and with the support of the United Kingdom Department for International Development (DFID), IrishAid and Canada's Department of Global Affairs.

To maximize the impact of counselling sessions, UNICEF worked with the Tanzania Food and Nutrition Centre to review and improve the integrated social and behaviour change communication package for accelerating stunting reduction. Modules on growth monitoring and promotion, Care for Child Development,[24] HIV screening, child protection, and water, sanitation and hygiene (WASH) interventions were integrated into IYCF programming as part of this review. UNICEF is also strengthening the capacities of community health workers by providing refresher training on the revised social and behaviour change communication package, with more than 1,000 workers trained to date.

The availability of IYCF counselling services within facilities also improved significantly in 2017. The proportion of health facilities with health staff trained on IYCF increased from 35 per cent in 2016 to 75 per cent in 2017, with a target of 100 per cent by 2021. A cumulative total of 1,550 health facility staff were trained to provide IYCF counselling services to pregnant women and caregivers of young children during antenatal and postnatal care visits. These results were achieved by UNICEF, in partnership with local government authorities, especially district and regional nutrition officers.

UNICEF used social mobilization events with local leaders and influential people to reinforce positive social norms and create a social environment that enables the adoption and maintenance of improved IYCF and related practices. The number of such influencers sensitized on the benefits of improved IYCF and related practices increased from 4,600 in 2016 to more than 20,000 in 2017, with the support of UNICEF and partner NGOs. These newly trained and sensitized local leaders were particularly effective in reaching men with IYCF awareness messages while promoting adoption of key behaviours.

To reach the most vulnerable households and improve equity, UNICEF ensured that caregivers who received conditional cash transfers were systematically enrolled into IYCF counselling services delivered by community health workers in focus regions, through a partnership with the Tanzania Social Action Fund and NGOs. To date, more than 50 per cent of cash transfer recipients in focus regions (90 per cent of them women) are attending nutrition services every month.

UNICEF and district nutrition officers conducted a bottleneck analysis on IYCF interventions in 2016 and 2017 to identify programmatic gaps. The analysis revealed that the capacities of community and health facility workers are still inadequate and that supplies such as social and behaviour change communication materials are still lacking in some places.

Over the next year, UNICEF will continue to support the scale-up of IYCF services in partnership with the government and NGOs, while fostering synergies between various programmes to ensure equity; further increase men's participation; and leverage additional funds to scale up IYCF interventions in other neglected regions.

Madagascar Ministry of Health in developing an ECD training package on early psycho-emotional stimulation, which was integrated into the IYCF training package for facility health workers. Training activities on the integrated package will be carried out in 2018, and the package will also be adapted for use by community health and nutrition workers. In Guatemala, UNICEF advocated for the creation of an inter-institutional special commission for early childhood, led by the Secretariat of Food and Nutrition Security and the Ministry of Education. In the past, the national strategy to prevent stunting placed only limited emphasis on responsive feeding and caregiving, whereas the new special commission will ensure that national nutrition frameworks for early childhood nutrition integrate early childhood stimulation.

Strengthening support for breastfeeding in maternity facilities

Timely and skilled breastfeeding support is a vital component of quality care during pregnancy, delivery and the postnatal period. This is reflected in the objectives of the UNICEF–WHO Baby-Friendly Hospital Initiative (BFHI), which provides guidance on the protection, promotion and support of breastfeeding in maternity facilities. The support provided by the BFHI is also part of the joint WHO–UNICEF Quality of Care initiative[25] on improving quality of care for maternal, newborn and child health, which was launched in February 2017. Between 2016 and 2017, UNICEF and WHO coordinated the update of the BFHI guidelines, which had not been updated since 2009 when they were first issued. The updated guidelines, to be published in 2018, focus on strategies to increase the coverage and sustainability of support to breastfeeding in maternity facilities, and are informed by case studies of implementation from a broad range of countries.

In line with BFHI guidance, many countries are scaling up training for health workers to improve breastfeeding support for new mothers in health facilities. In Bangladesh, more than 35,000 health workers were trained on IYCF competencies across the country and IYCF counselling was provided to 2.8 million caregivers, an increase from 29 per cent of caregivers in 2016 to 52 per cent in 2017. This support has helped transform district nutrition governance, delivery and use of nutrition services. About 80 per cent of facilities report providing counselling to caregivers on IYCF and 76 per cent of facilities report being equipped with essential nutrition supplies compared with 5 per cent in 2015.

To support the BFHI agenda in the Niger, UNICEF worked with the Nutrition Directorate to conduct an assessment in four regions covering 40 hospitals. The findings revealed that no hospital met BFHI standards, and UNICEF responded by supporting the scale-up of BFHI training in six maternity hospitals. In Malawi, UNICEF identified key bottlenecks to improved breastfeeding, including the limited capacity of health workers and the lack of an enabling environment in health facilities. Consequently, UNICEF provided technical and financial support to establish breastfeeding 'corners' in maternity hospitals where mothers have access to breastfeeding support and counselling. As a result of UNICEF advocacy at the national level, 'baby corners' have now been adopted by the Malawi Ministry of Health to improve breastfeeding in all maternity facilities.

Baby Tolgonay enjoys breakfast in the family yurta (tent) with her mother, father and grandmother in Kyrgyzstan.

With UNICEF technical guidance, the Government of Guinea-Bissau revitalized implementation of the BFHI in 2017 and produced training curricula to support its institutionalization across the country. To facilitate these efforts, UNICEF built capacity within the Ministry of Health to reinstitute mother-to-mother support groups. A South–South cooperation agreement was also established between Guinea-Bissau and Cabo Verde to train staff and improve national capacities for institutionalizing the BFHI in the country.

Generating evidence and improving strategies for complementary feeding

In 2017, UNICEF continued to expand the knowledge base for improved nutrition, including by leading the development of a special issue of the international journal *Maternal and Child Nutrition* on complementary feeding under the theme 'First foods: Improving diets in early childhood'. The issue included 15 papers and was launched during the International Conference on Nutrition in Buenos Aires, reinforcing UNICEF's position as a global leader in early childhood nutrition. In Pakistan, evidence was needed on the main determinants of complementary feeding practices, including those pertaining to social and cultural beliefs and practices and gender inequalities. Recognizing this need, UNICEF launched a national assessment of the quality of complementary foods and feeding practices. Among a number of findings, the analysis showed that only 15 per cent of young children were receiving the minimum acceptable diet, with less than one in five children consuming legumes, meat, fish and vitamin A-rich fruits and vegetables; and that the involvement of mothers in major household purchases was positively associated with the consumption of a greater number of food groups. The study findings have been disseminated at federal level and formative research on child feeding and a 'cost of diet' study are in progress. This research will inform the design of gender-responsive complementary feeding programmes.

Many countries are piloting new strategies for improving children's diets to inform programme scale-up. In the Plurinational State of Bolivia, UNICEF, the Food and Agriculture Organization of the United Nations (FAO) and the United Nations Industrial Development Organization (UNIDO) developed a joint multisectoral programme for improving girls' and boys' nutrition in four municipalities of Cochabama and Potosí. The programme used a Communication for Development (C4D) strategy, implemented in coordination with the Bolivian Ministry of Health, to strengthen local food systems and improve feeding practices with locally available foods. The programme was evaluated in 2017, showing important achievements: the proportion of families facing food insecurity in the four municipalities decreased from 96 per cent to 73 per cent; the diversity of foods consumed by children 6–59 months of age increased from 4.2 food groups to 6.5 food groups;[26] and the proportion of families with young children adopting optimal food and nutrition practices nearly doubled, from 24.5 per cent to 48.6 per cent. The programme served as an important model for improving food and nutrition security in the country and the national government has agreed to replicate it in other municipalities as part of the Multi-sectoral Food and Nutrition Plan.

As complementary feeding programmes improve, countries are working to document and share best practices to improve future programming. UNICEF supported the Ethiopian Ministry of Health in conducting a complementary feeding workshop to take stock of the lessons learned and develop an action plan for improving children's diets in Ethiopia. The multi-stakeholder workshop was an opportunity to identify bottlenecks and devise a series of recommendations to improve community knowledge of good complementary feeding practices; increase access to and availability of meat, dairy, vegetables and fruits; and build the capacities of health workers. In 2018, UNICEF will support the Ministry of Health in developing a quality of care framework to guide community-based structures in supporting the nutrition challenges of vulnerable groups.

Through expert consultations and high-level regional meetings, UNICEF outlined priorities for action on the role of food systems in child nutrition, and highlighted the potential for schools to deliver nutrition interventions. In Europe and Central Asia, FAO, UNICEF and the World Food Programme (WFP) co-organized a symposium on sustainable food systems for healthy diets, bringing together governments and key stakeholders from 15 countries to address multisectoral actions for tackling the triple burden of malnutrition in Europe. The meeting resulted in an agreement to establish a regional nutrition capacity-building network and partnership platform to spur further action on this issue.

SPOTLIGHT ON INNOVATIONS: STRENGTHENING LINKS WITH AGRICULTURE

In Ethiopia, UNICEF sought to strengthen linkages with the agriculture sector to improve complementary feeding practices. As part of this effort, UNICEF supported the Ministry of Health and the Ministry of Agriculture and Natural Resources to develop a training for health extension workers and agriculture development agents on infant and young child nutrition and nutrition-sensitive agriculture. More than 2,480 agricultural development agents and the same number of health extension workers were equipped with better skills and knowledge on nutrition-sensitive agriculture.

Implementing guidance on infant feeding and HIV

WHO and UNICEF released new guidelines on HIV and infant feeding in 2016.[27] In 2017, UNICEF worked with various countries to translate these guidelines into practice. UNICEF provided technical assistance to Lesotho, South Africa and the United Republic of Tanzania to revise national action plans for the prevention of parent-to-child transmission (PPTCT) of HIV, bringing them in line with the new HIV and infant feeding guidelines. In South Africa, UNICEF fostered policy dialogue to ensure evidence-based decision-making during the revision of the country's HIV clinical guidelines in 2017. This included convening a working group of technical experts and programme managers in PPTCT and nutrition to review and discuss the HIV and infant feeding global guidelines in the South African context and share available evidence. UNICEF also led a consultation meeting on a postnatal service delivery platform for implementing the guidelines at facility and community levels.

To integrate the new guidelines into service delivery in Lesotho, UNICEF contributed to national consultations and provided technical guidance to revise and update the country's IYCF counselling materials. UNICEF also supported capacity-building for more than 170 health workers on the new guidelines. Plans are in place in Lesotho to conduct focus group discussions with breastfeeding mothers to document experiences of, barriers to and recommendations for optimal breastfeeding in the context of HIV; and a training video will be made based on such experiences.

Making advocacy count

UNICEF and its partners have sparked important advancements in the global landscape of infant and young child nutrition over the past year as a result of concerted and strategic advocacy. The most visible manifestation of this work has been the achievements of the Global Breastfeeding Collective (formerly, the Breastfeeding Advocacy Initiative), a partnership with more than 20 members led by UNICEF and WHO to increase political commitment to and financial investments in breastfeeding. In 2017, UNICEF and partners developed a brand identity and strategy with the support of a global communications firm to communicate breastfeeding as an aspirational behaviour and to help gain the commitment of policymakers and funders to effectively mobilize support for women to breastfeed.

As part of its public launch during World Breastfeeding Week 2017, the collective released three important advocacy products: an investment case demonstrating how breastfeeding saves lives and money and makes nations healthier for generations to come;[28] a global breastfeeding scorecard used to track global and country progress against seven key policy recommendations set forth in the collective's call to action;[29] and a new partnership website, including an interactive dashboard of country-specific data on breastfeeding policies in all countries.[30]

The release of the investment case and scorecard generated significant media coverage in top-tier media outlets (at least 2,000 print, online and broadcast media in six languages) and, together with UNICEF's World Breastfeeding Week posts, reached an estimated 545 million people via social media, with active engagement by more than 190,000. Events highlighting the new investment case and scorecard and its implications for countries were conducted in Indonesia, Nigeria and the Philippines, among others, with high-level participation of government policymakers and other key stakeholders.

In 2017, UNICEF continued its advocacy for improved IYCF practices with parliamentarians. Together with the Inter-Parliamentary Union, Alive & Thrive, and with the support of the National Assembly of Burkina Faso, UNICEF supported members of parliament from 20 countries via a workshop on promoting maternal and child nutrition in West and Central Africa. Parliamentarians issued a joint declaration outlining priority actions and established a global community of active parliamentarians in nutrition to share experiences from different countries and regions.

Within countries, advocacy for improved child nutrition led to increased budgets and financial commitments. In India, UNICEF supported 15 state governments to plan and implement the Mothers' Absolute Affection programme, a nationwide breastfeeding promotion programme launched by the Ministry of Health and Family Welfare. The programme has now been rolled out in more than 500 districts nationally with the aim of improving skilled support to mothers. To ensure implementation in poorly performing states, UNICEF supported state governments in developing dedicated budgets in annual health plans to improve the knowledge and skills of facility and community-level health-care providers to support optimal breastfeeding. UNICEF assisted the Government of India with television and radio spots to support positive behaviour change for infant and young child nutrition, helped develop communications toolkits and supported programme monitoring.

Strengthening IYCF policies, strategies and legislation

Strong national policies and legislation are essential to improving breastfeeding practices. The International Code of Marketing of Breast-milk Substitutes[31] and subsequent World Health Assembly resolutions (known together as 'the Code') aim to protect and promote breastfeeding by prohibiting the promotion of breastmilk substitutes, such as infant formula, feeding bottles and teats. UNICEF provides technical support to governments to fully implement the Code through the adoption, monitoring and enforcement of national legislation. In 2017, such guidance was provided to the governments of Kenya, Lao People's Democratic

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Ms Shumi, day-care provider at a ready-made garment factory in Bangladesh, oversees the breastfeeding room where women can breastfeed or express breastmilk. The day-care centre and breastfeeding room were established with technical and advocacy support from UNICEF.

Republic, Lesotho, Mongolia, the Niger, Pakistan, the Philippines, Somalia, Timor-Leste and Zambia to either draft national measures or strengthen existing Code legislation that fell short of the international standard.

There are now 136 countries with at least some form of legal measure in place covering some or all the provisions of the Code. UNICEF country offices report on the adoption of national Code legislation as part of the organization's strategic monitoring questions, reflected in indicator P4.c.1 of the strategic plan: 86 UNICEF programme countries had adopted the Code into national legislation in 2017, exceeding the target of 85.

Following years of ongoing support from UNICEF, the governments of Mongolia and Thailand adopted national Code regulations in 2017. In addition to banning advertising for breastmilk substitutes, Mongolia's new legislation defines the responsibilities of health professionals in avoiding conflicts of interest and provides provisions for coordination mechanisms to protect breastfeeding and promote stakeholder accountability. UNICEF's continued advocacy for Code legislation in Thailand led the government to eventually pass the Control of Marketing of Infant and Young Child Food Act in 2017. UNICEF garnered public support for the law, advocated with law review committee members and provided technical support to the Ministry of Public Health to bring the law into effect. Together with the International Baby Food Action Network, UNICEF trained national 'Code watchers' at the country's 13 health promotion centres to monitor the new law's implementation.

As reported last year, many countries have good Code legislation in place but still lack adequate monitoring and enforcement systems, and while some have identified a monitoring body, the work of that group may not be carried out consistently. UNICEF and WHO are therefore leading an initiative known as the Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes and Subsequent relevant World Health Assembly Resolutions (NetCode). The goal of NetCode is to strengthen Member States' and civil society capacity to monitor the Code, and to facilitate the development, monitoring and enforcement of national Code legislation by Member States, by bringing together a group of committed actors to support these processes. During 2017, UNICEF, WHO and partners worked to improve the resources available to governments and civil society, developing a toolkit for ongoing monitoring and periodic assessment of Code implementation.[32]

There are ongoing efforts by a number of governments to design and strengthen national strategies for improving

complementary feeding. In Myanmar, UNICEF has made inroads in improving the policy environment for complementary feeding in response to the latest national survey data showing that more than 80 per cent of children aged 6–23 months are not being fed the minimum acceptable diet. In 2017, UNICEF supported the Myanmar National Nutrition Centre in creating a 'child bowl', a communications tool for promoting diversified diets. The bowl can be used by health workers providing counselling on complementary feeding and will also be linked to a strategic communications campaign being carried out by UNICEF, the Ministry of Health and other partners. Inspired by the child bowl concept, FAO and other partners are developing a 'maternal plate' to promote improved maternal diets, and the two tools will be launched together as part of a national social and behavioural change strategy on nutrition.

Improving workplace policies to support breastfeeding

Supportive workplace policies – such as the provision of paid maternity leave, breastfeeding breaks and designated nursing spaces – are critical for encouraging breastfeeding and promoting gender equality. In Bangladesh, UNICEF launched its Mothers@Work programme in 2017, aiming to strengthen maternity rights and protect breastfeeding in the workplace. The programme is implemented in partnership with government, the ready-made garment sector and civil society organizations. In its first year alone, the programme reached more than 7,000 workers (80 per cent of them women) in five garment factories and is now being scaled up in partnership with the International Labour Organization (ILO) across other factories in Bangladesh.

UNICEF is increasingly supporting countries in developing breastfeeding-friendly workplace strategies. In 2017, UNICEF developed C4D strategies for promoting and supporting breastfeeding in the workplace in Bangladesh and Kenya, including detailed monitoring and evaluation plans (*see 'Cross-cutting programme areas'*). As part of a 'breastfeeding in the workplace' initiative in Thailand, UNICEF supported the Ministry of Public Health to produce an advocacy package targeting the business sector. In Mexico, as part of a 'child rights and business' initiative, UNICEF developed guidelines on the design of breastfeeding-friendly spaces, which were used to establish 70 breastfeeding spaces in various private sector companies in 2017.

CHALLENGES, REFLECTIONS AND FUTURE DIRECTIONS

There have been important lessons learned over the 2014–2017 period, which will help to refocus UNICEF's programme strategies in the future. Improving the diversity of children's diets continues to be a challenge, with only one in four children under 2 years of age in developing countries being fed food from the minimum number of food groups. Programme experience, combined with the counselling evaluation in Nigeria, has shown that counselling is essential to improving dietary diversity, but on its own may not be sufficient. Greater efforts must be made to improve the availability of, acceptability of and access to nutrient-rich foods and to scale up complementary feeding programmes. Evidence generation on complementary feeding is accelerating in many countries and will inform programme design and implementation in 2018 and beyond.

Strengthened multisectoral collaboration, including with the agriculture sector, will be critical to improving children's diets and increasing the availability of nutritious local foods. Links with social protection programmes can help make food more affordable to families and ensure that cash and other social transfers benefit the youngest children. Increasingly, point-of-use fortification with micronutrient powders (*see 'Programme Area 2'*) is being integrated into IYCF programmes, which is effective at boosting the nutritional value of family foods while improving feeding practices more generally.

There is also good evidence that food is more readily accepted when caregivers use responsive feeding and stimulation, hence the importance of integrating child stimulation as part of the early childhood nutrition continuum. ECD programmes must continue to encourage good communication between caregiver and child, which also contributes to self-regulation and the prevention of overweight.

In 2018, UNICEF will continue co-leading the Global Breastfeeding Collective and NetCode with WHO, and will accelerate support for regional- and country-level advocacy with an engagement strategy and context-specific advocacy tools. There is also a need to strengthen data collection and monitor key IYCF indicators routinely. Only one in five health information systems track progress on IYCF indicators,[33] and UNICEF will play an important role in improving the monitoring of key nutrition indicators.

As UNICEF transitions into its next strategic plan, the infant and young child nutrition programme area will continue its current work, while accelerating efforts to improve diets, prevent overweight and obesity, promote sustainable food systems and ensure food security in early childhood – when it matters most.

Until now, most of the funding for programme area 1 has been earmarked for specific projects. A wide and flexible funding base will prove critical to responding to these demands over the course of the next strategic plan (2018–2021). Specifically, greater resources are needed for implementing comprehensive breastfeeding programmes; for implementing complementary feeding programmes informed by situation analyses and formative research; and for advancing the critical and often neglected work around the prevention of overweight and obesity in early childhood.

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The chef adds iodized salt to the nutritious meals prepared for children at Ouirgane Secondary School in Marrakech, Morocco.

Programme Area 2: Micronutrient supplementation and food fortification

SMALL BUT POWERFUL

Essential vitamins and minerals – known together as micronutrients – are important building blocks of children's physical and mental development. While they are only needed in tiny quantities, their absence from children's diets can threaten their survival and lead to devastating consequences, including stunting, wasting, weakened immunity and delays in cognitive development. Similarly, during pregnancy, deficiencies in essential vitamins and minerals can wreak havoc on a woman's own health and jeopardize the survival and development of her growing child.

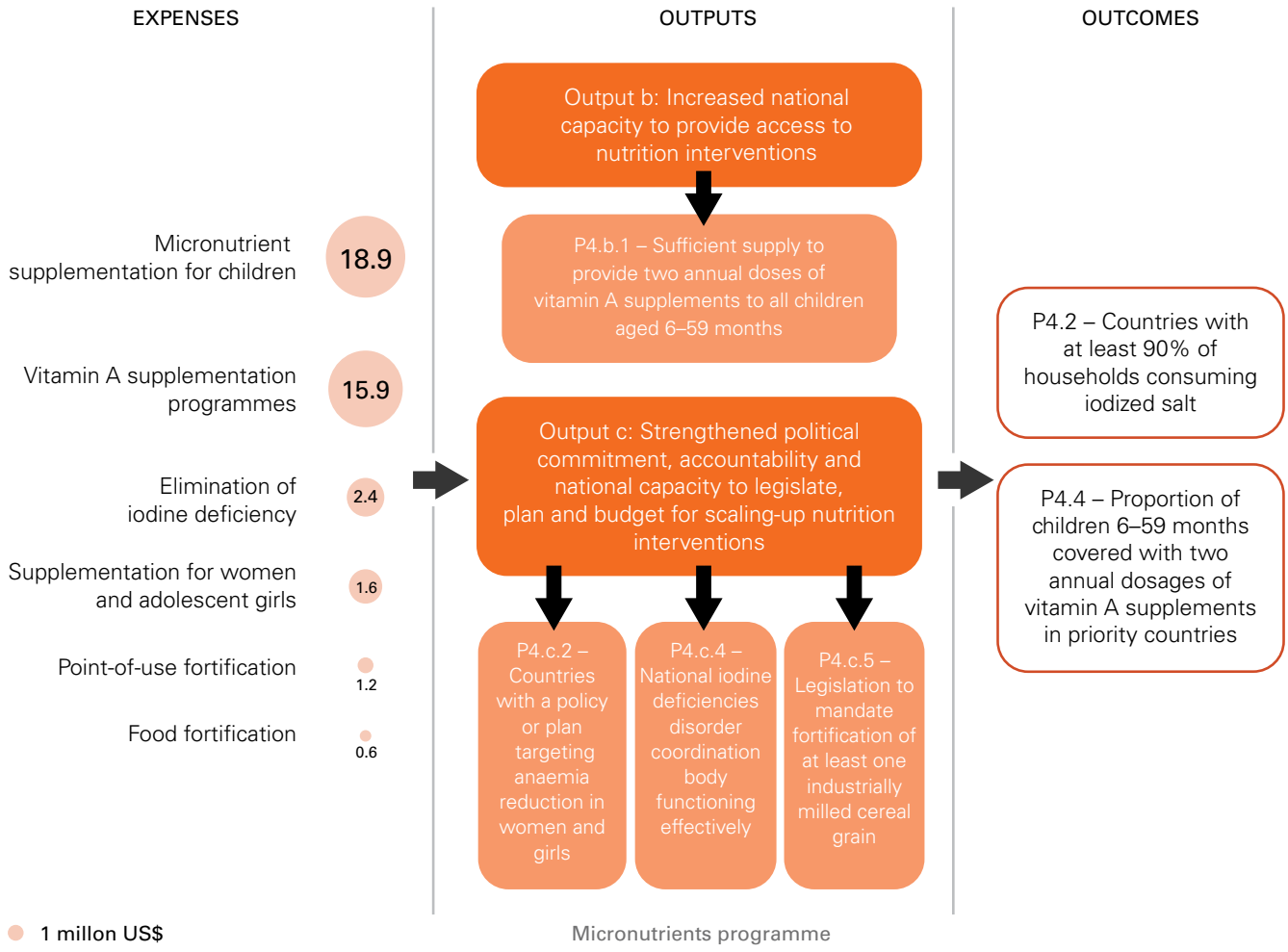
Nutritious diets, including meals from a diverse range of food groups, are the best way to prevent micronutrient deficiencies. But, until good nutrition is a reality for every family, micronutrient supplementation and fortification programmes can help protect children's growth and development, and ensure equity. To deliver essential micronutrients to children and women, UNICEF uses strategies such as supplementation (e.g., delivering high-dose vitamin A supplements); fortification of industrially produced foods and condiments (e.g., salt iodization, fortification of cereal grains); and point-of-use fortification[34] (i.e., adding micronutrient powders to homemade foods) to deliver micronutrients to children and women. These strategies must be combined with efforts to improve household access to nutritious foods year-round and to prevent and treat infectious diseases.

In addition to delivering services in selected circumstances, UNICEF builds the capacities of governments to improve micronutrient policies and strategies, and works to expand the evidence base on micronutrient interventions for children and women. At the global level, UNICEF convenes a number of key partnerships, generating evidence to inform policy and providing global guidance. In 2017, UNICEF continued to play a leadership role on the executive boards and coordination committees of the Food Fortification Initiative, Global Alliance for Vitamin A, Home Fortification Technical Advisory Group, Iodine Global Network, International Zinc Nutrition Consultative Group, Micronutrient Forum and the Scientific Organizing Committee of the Taskforce on Multiple Micronutrient Supplementation during Pregnancy. This involvement has helped UNICEF steer the micronutrients agenda, contribute to the global knowledge base and better support the technical needs of countries.

RESULTS CHAIN FOR MICRONUTRIENTS

The results chain for Programme Area 2 describes the linkages between programme spending, key interventions and progress on the UNICEF strategic plan output and

FIGURE 6: Results chain for micronutrients



outcome indicators (*see Figure 6*). Full data on the strategic plan indicators are presented in the pages that follow and in Annex 1.

In 2017, US$40.9 million was spent on micronutrients programming, a decline from US$79 million the previous year. This decline is related to both the lower availability of resources in the last year of the strategic plan period and, potentially, greater ownership of programmes by national governments. In 2017, the largest proportion of resources, US$18.9 million, was allotted to supplementation programmes to prevent anaemia and other micronutrient deficiencies in young children.

OUTPUTS AND RESULTS IN 2017

Delivering life-saving protection with vitamin A supplementation

Vitamin A supplementation (VAS) has been a cornerstone of early childhood nutrition programmes for more than two decades. From 6 to 59 months, two high doses of vitamin A every year can prevent blindness and hearing loss, boost children's immunity against diseases such as measles and diarrhoea, and provide critical protection against death.

A baby receives a dose of vitamin A at an early childhood development event in the stadium of Kabale Municipality in south-western Uganda.

Globally, UNICEF is the main provider of vitamin A supplements, supported by an in-kind donation financed by the Government of Canada and implemented through Nutrition International (NI). At least 250 million children in need were reached with VAS each year, between 2014 and 2016. VAS is often delivered with deworming prophylaxis, and in 2017, thirty-four countries in sub-Saharan Africa (i.e., 69 per cent of countries in the region) delivered deworming with VAS to children under 5 years of age. In 2017, UNICEF and NI supplied approximately 553.97 million vitamin A capsules (a 23 per cent increase from the previous year) to 58 priority countries, and supported national efforts to improve inventory management and reduce wastage in the supply chain to meet the strategic plan indicator on vitamin A supply. The number of countries with sufficient supply to provide VAS to all children in need increased from 61 in 2016 to 70 in 2017 (P4.b.1).

In the past, VAS was scaled up successfully in many settings by integrating its delivery into National Immunization Days (NIDs) for polio eradication. However, with the success of eradication efforts, polio NID campaigns are being phased out rapidly in most countries, leaving many governments struggling to sustain VAS programmes without this effective delivery platform and its financing. At the same time, weak routine health services in many parts of West and Central Africa, South Asia, and Eastern and Southern Africa continue to pose challenges to delivering VAS twice a year to all children.

These challenges have left VAS programmes at a crossroads in many countries and contributed to a dip in global coverage rates. The latest estimates indicate that 250 million children aged 6–59 months – only 64 per cent of children in need – received two annual doses of vitamin A supplements (P4.4). This figure represents a decline in coverage from the baseline of 68 per cent, and from the previous year, when 70 per cent of children in need were reached. The challenge of sustaining high VAS coverage without the NIDs platform and its funding can be seen in the experience of the Niger, where 90 per cent coverage was achieved for the first dose of VAS using NIDs campaigns, but the critical second dose was only delivered in districts with a high polio burden, due to limited resources and capacity. UNICEF is working to mobilize global action and resources to respond to the alarming decline in global VAS coverage and, in early 2018, will publish a detailed report outlining key gaps and a way forward.

As NIDs are scaled back, a number of countries are working to strengthen the delivery of VAS through routine health service contacts. In Mali, for example, UNICEF provided policy guidance to develop a VAS transition strategy that calls for strengthening of delivery through routine health contacts in the phase-out of campaign-based delivery. Planning, political commitment and financing have been critical for shifting VAS delivery platforms successfully. In some regions of Ethiopia, VAS coverage dipped in 2015 and 2016 as regional governments transitioned from campaigns to routine health service delivery. UNICEF, in collaboration with NI, strengthened advocacy to prioritize the nutrition programme in these regions in 2017; as a result, VAS coverage rose to 80 per cent (more than 3.8 million children). Under the leadership of the Ministry of Health of Ethiopia, the transition in service delivery continued throughout 2017, whereby 430 *woredas* (districts) out of more than 800 began delivering VAS and deworming through the routine health system.

With financing from Global Affairs Canada, similar work is under way to support transitional approaches in 15 countries in sub-Saharan Africa. One key challenge is to ensure that transition processes continue to reach all children 6–59 months of age with VAS, and not just younger children receiving vaccinations. Burkina Faso is one country that has begun distributing VAS through community health workers, which helps to reach older children who may not come as regularly to health facilities.

Some governments are integrating VAS delivery into immunization services, as part of a health systems strengthening approach. In Eastern and Southern Africa, UNICEF helped countries integrate VAS into an expanded programme on immunization services in Burundi, Kenya, Madagascar, Malawi, South Sudan, Uganda, the United Republic of Tanzania and Zambia. In Kenya, for example, UNICEF provided technical support to develop a new policy for VAS delivery through community health workers and early childhood development centres to increase and sustain coverage.

With UNICEF support, governments are also working to make VAS programmes more equitable, ensuring that the most vulnerable children are fully protected from the consequences of vitamin A deficiency. In 2017, UNICEF worked with the Government of the United Republic of Tanzania to reduce the disparities in coverage between the mainland and Zanzibar, and supported district-level planning in low-performing districts to close the gaps in coverage. With the support of the Tanzania Food and Nutrition Centre, UNICEF delivered VAS and deworming services to all districts, reaching boys and girls in equal numbers. National coverage increased from 89 per cent in 2016 to 92 per cent in 2017. A bottleneck analysis was conducted in lower-performing districts, which identified poor supply chain management and insufficient service providers as key barriers. UNICEF will provide targeted support to boost coverage equity in these districts in 2018.

UNICEF also expanded the evidence base for VAS in 2017, working with the Global Alliance for Vitamin A to develop evidence briefs on postpartum vitamin A supplementation and VAS delivery using a routine health visit at 6 months of age.

SPOTLIGHT ON INNOVATIONS: REAL-TIME DATA TO IMPROVE PROGRAMME PERFORMANCE IN BURUNDI

Using Short Message Service (SMS) technology supported by UNICEF, the Government of Burundi has addressed important challenges in delivering VAS, including poor supply monitoring, delayed reporting and difficulties ascertaining the number of missed children. The technology allows service providers to send programme data using their personal phones to a RapidPro server, from which programme managers can track programme implementation in real time. The RapidPro system provides an overview of how services are being used, helps prevent stock shortages and provides a database for prioritizing and organizing activities. The system also provides a mechanism for tracking distribution events and helps managers respond to problems as they occur.

A community health worker adds micronutrient powder to a child's food during a demonstration in a nutrition counselling and care group meeting in Uwabumenyi village in Nyamagabe District, Rwanda.

CASE STUDY 3: BANGLADESH: DELIVERING VITAL NUTRITION SERVICES TO ROHINGYA REFUGEE CHILDREN IN COX'S BAZAR

The influx of Rohingya refugees from northern Myanmar into Bangladesh restarted in August 2017, and by November 2017, some 615,500 new refugees had arrived, almost a third of whom were children. A nutrition assessment conducted at Kutupalong refugee camp in Cox's Bazar showed a 7.5 per cent prevalence of life-threatening SAM – double the rate seen among Rohingya child refugees in May 2017.

In response to the crisis, the Government of Bangladesh and UNICEF coordinated a 'Nutrition Action Week' campaign, a multi-partner initiative, mobilizing more than 900 stakeholders and community leaders to deliver critical nutrition services[35] to children in need. Planning began with district-level advocacy to bring all nutrition stakeholders together and collectively agree on the interventions, targets and a service distribution approach. A series of planning and capacity-building meetings was then organized to develop micro-plans by settlement/camp with site targets for each intervention. Team leaders visited the settlements to engage with local leaders and 70 campaign teams were trained to conduct the campaign.

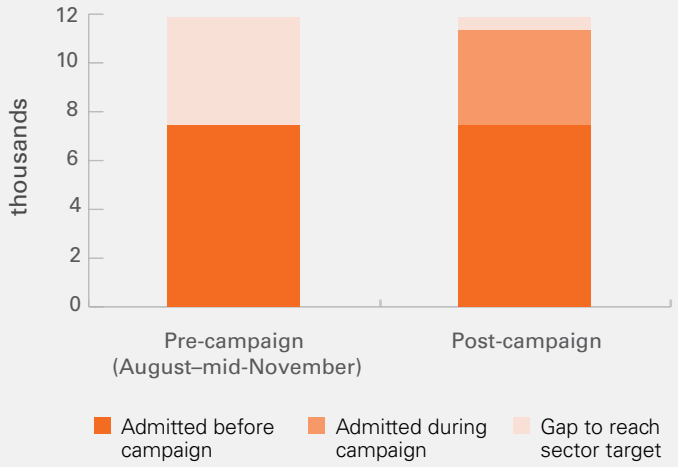
The campaign began with fixed distribution sites in each settlement, and then split into mobile distribution teams in 105 mobile sites to ensure that no child was missed. UNICEF also advocated for support from the army, through which about 200 head *mazis* (refugee camp leaders) and 2,000 other camp leaders were mobilized. These leaders helped identify distribution sites and assisted in site planning, serving as advocates to promote the Nutrition Action Week and mobilize caregivers to attend the event.

Campaign teams tracked supplies and service delivery in real time using mobile phones, and the data were automatically analysed against the set targets via an online dashboard. This innovation allowed the campaign to be assessed by distribution site, with the dashboard linked to the government's health management information system.

More than 164,700 refugee children were screened during the campaign – 93 per cent of the planned target. The campaign delivered VAS and deworming to 88 per cent of children aged 6–59 months, exceeding the programme target of 80 per cent, with uniform programme performance across all settlements – an indication of equity. The VAS coverage achieved through the campaign was significantly higher than the VAS coverage achieved using earlier measles and cholera campaigns (which was only about 40 per cent). The Nutrition Action Week campaign was also more effective in that it was able to reach caregivers with counselling, though further improvements are still needed.

As a result of the nutritional screening, more than 4,000 children were identified as having SAM and 95 per cent of them were admitted to outpatient treatment programmes. The average admission in these programmes increased from 130 children in the week prior to the campaign, to 396 children through the Nutrition Action Week campaign. Of the children coming to outpatient therapeutic sites, more than 80 per cent had first gone to the campaign distribution site before being referred, which shows the campaign's effectiveness in boosting admissions. Overall, the campaign increased admissions for SAM from 63 per cent before the campaign, to 95 per cent by its completion (*see Figure 7*). These admissions contributed to meeting 33 per cent of the overall six-month sector admissions target in only one week.

FIGURE 7: Number of children with severe acute malnutrition admitted for treatment before and after the campaign



UNICEF supported the post-campaign transition, developing a strategy to institutionalize screening and referral processes. This consolidation phase also included improving reporting on key indicators and strengthening the overall quality of care and screening.

Lessons learned included the importance of collaborating with a wide group of partners and stakeholders; the success of engaging with army and camp leaders to mobilize support; and the effectiveness of leveraging innovations, such as real-time monitoring to reduce supply gaps, and track performance and coverage reporting.

Based on the success of the campaign and informed by the lessons learned, the Government of Bangladesh will conduct a National Nutrition Week campaign in April 2018, across all 64 districts of Bangladesh, delivering the package of nutrition interventions to 17 million across the country. A second Nutrition Action Week in Cox's Bazar refugee camp will also be carried out in mid-2018 to ensure delivery of a second, appropriately spaced VAS dose.

Enhancing dietary quality with point-of-use fortification programmes for children

Point-of-use fortification programmes improve the quality of children's diets by providing caregivers with multiple micronutrient powders (MNPs) to add to the foods they prepare for young children. Given the high nutrient needs of children aged 6–23 months and the fact that only about one quarter[36] of them have access to a diverse diet,[37] point-of-use fortification programmes provide a good opportunity to maximize nutrient intake while preventing anaemia and other micronutrient deficiencies.

Globally, the number of countries implementing point-of-use fortification programmes has more than doubled over the past six years with UNICEF support, increasing from 22 countries in 2011 to 62 countries in 2016 (the most recent data available). UNICEF is the largest procurer of MNPs and plays a leading role in developing the market, ensuring supply and stimulating demand. About 15.6 million children were reached with MNP programmes in 2016, an increase of 5.5 million from the previous year and more than three times the number reached in 2014. More than 29.6 million children were reached over the entire 2014–2016 period. To support this expanded programme reach, MNP procurement increased 340 per cent over the strategic plan reporting period, from 346 million sachets in 2014 to 1.185 billion sachets in 2017.

With UNICEF support, more than three quarters of all MNP interventions are integrated within IYCF programmes to improve nutrient intake from complementary foods.[38] In 2017, UNICEF published a review of evidence on the contribution of MNP to improving complementary feeding[39] and contributed to a journal supplement on lessons learned and operational guidance on MNP programmes.[40] The supplement reviews country experiences with MNPs and offers a framework for using MNPs to strengthen feeding practices.

In its support for scaling up point-of-use fortification programmes, UNICEF provides policy guidance, procures commodities, promotes behaviour change communication and supports programme monitoring. In Rwanda, UNICEF procured supplies, developed the capacities of service providers, improved supply chain management and integrated monitoring structures within different information management platforms. In 2017, the programme was scaled up to all 30 districts, achieving nearly 80 per cent coverage by October 2017 and reaching more than 432,600 children aged 6–23 months. A supply end-user monitoring exercise was carried out to support this process and the findings will inform UNICEF support to government systems strengthening in 2018. With UNICEF support in the Niger, point-of-use fortification programmes were expanded from 12 municipalities in 2016 to 17 municipalities in 2017, increasing the number of children reached from about 72,700 to more than 84,500.

With UNICEF advocacy, MNP interventions are being included within the nutrition strategies of many countries. In Nepal, district nutrition plans were finalized and implemented in 30 districts and UNICEF supported the Ministry of Health to deliver MNP as part of IYCF interventions in 27 districts. More than 351,700 children 6–23 months of age (87 per cent of those targeted) received MNP as part of the programme. In response to the emergency in the north-east Nigeria, more than 451,000 children received MNPs through visits at 585 sites and through mass campaigns, and more than 577,000 caregivers received counselling on IYCF practices. In 2018, UNICEF will support the provision of MNP through campaigns while piloting their distribution in a routine approach in some states.

Fostering nutrition with micronutrient supplementation for adolescent girls and women

UNICEF supports micronutrient supplementation programmes for adolescent girls and women to prevent anaemia and improve maternal and child health. These programmes are particularly important in settings where girls and women have limited access to nutritious diets and where early marriage and early pregnancy are common.

Adolescent girls participate in physical activity during a youth programme in Madanpur Jamua block of Giridih, Jharkhand State, India.

To support programme scale-up, UNICEF's procurement of iron and folic acid tablets increased to 1.414 billion tablets in 2017, from 334.8 million tablets the previous year.

National policies and strategies on anaemia reduction in women of reproductive age are an important indicator of programme performance, as reflected in the UNICEF Strategic Plan, 2014–2017 (P4.c.2). Such programmes are also a part of the UNICEF Gender Action Plan as they help promote equity. In 2017, there were 91 countries (76 per cent) with such a policy or plan, a significant increase from 79 countries in 2016 (65 per cent). Of these countries, 56 (46 per cent) also had a specific approach within their national policy to combat anaemia among adolescent girls, an improvement from only 41 (34 per cent) the previous year and exceeding the strategic plan target of 50 countries. The path to improving national policies can be long and requires strategic advocacy with key stakeholders. In Bangladesh, sustained policy advocacy by UNICEF over a number of years resulted in mainstreaming of strategic actions, interventions and delivery platforms for adolescent nutrition – such as iron and folic acid supplementation – into the National Adolescent Health Strategy in 2017.

UNICEF works to expand the knowledge base for maternal and adolescent nutrition programmes, grounding its advocacy and programming in the latest evidence. In 2017, UNICEF, WHO and NI had a journal supplement published on implementation considerations for multiple micronutrient supplementation (MMS) and maternal nutrition.[41] The latest WHO antenatal guideline states that MMS may benefit maternal health, but more evidence is needed before a global recommendation can be issued.[42] To help strengthen this evidence base, UNICEF is a member of the Scientific Organizing Committee of a task force on the issue,[43] which conducted a consultation in 2017 to review recent evidence on MMS and propose a road map to guide country decision-making. In India, UNICEF provided support to the Ministry of Health to convene a national dialogue on the evidence for maternal nutrition interventions. UNICEF provided technical assistance to draft guidelines for the prevention and management of maternal malnutrition and launched an evidence-gathering exercise to test the guidelines at Kalawati Saran Children's Hospital. In Indonesia, UNICEF expanded the evidence base for adolescent nutrition, laying the foundation for key policy improvements (*see Case Study 7*).

The scale-up of iron and folic acid supplementation programmes for adolescents continued in several countries throughout 2017 (*see Case Study 4*). The weekly iron supplementation programme in Afghanistan achieved 97 per cent coverage in 2017, reaching about 1.6 million adolescent girls in 33 provinces. This was a significant increase from 2016, when the programme reached about 984,400 girls in 10 provinces. The programme is delivered in schools, and programme reach was expanded in part as a result of UNICEF capacity-building efforts with teachers, school management *shuras* (supervisors), religious leaders and academic supervisors. At the same time, insecurity in some regions impacted programme delivery and there continue to be bottlenecks around community perceptions of the intervention. Resource constraints also precluded reaching out-of-school girls in 2017. To address some of these challenges, UNICEF is launching a national media campaign to improve awareness, while working with government and other partners to improve programme performance-based supportive supervision and to provide refresher training for those delivering services.

Other countries are also strengthening the capacities of health providers to deliver services for anaemia prevention and control. In focus regions of the United Republic of Tanzania, UNICEF supported the scale-up of capacity-building training for community health workers, increasing the proportion of community health workers trained to counsel on anaemia prevention from 15 per cent (460 villages) in 2016 to 64 per cent (more than 1,950 villages) in 2017. There are now more than 4,000 community health workers providing counselling to pregnant and lactating women on anaemia prevention. The presence of this skilled support helped boost the national coverage of pregnant women and adolescents receiving iron and folic acid at an antenatal care clinic from 20 per cent in 2016 to 26 per cent in 2017. To improve equity, UNICEF supported bottleneck analysis, and helped improve nutrition planning and supportive supervision in low-performing districts.

CASE STUDY 4: INDIA: TOWARDS AN ANAEMIA-FREE FUTURE WITH WEEKLY IRON AND FOLIC ACID SUPPLEMENTATION

India has the largest universal adolescent weekly iron and folic acid supplementation (WIFS) programme in the world, aiming to eventually reach 116 million adolescent girls and boys. The programme protects adolescents from the debilitating effects of anaemia and plays a pivotal role in breaking the country's intergenerational cycle of malnutrition. Nationwide, coverage of the programme increased from 29 million adolescent girls and boys in 2016 to 36 million in 2017; all programme components were budgeted for in the Ministry of Health annual action plans.

The WIFS programme is led by the Adolescent Health Division of the Ministry of Health and Family Welfare in close coordination and partnership with the Ministry of Education and the Ministry of Women and Child Development. The Ministry of Health and Family Welfare provides overarching support to the 32 states to prepare plans of action, earmark annual budgets, facilitate reviews and apply approaches to improve coverage by including disadvantaged subpopulations.

The Ministry of Education is responsible for ensuring the administration of iron, folic acid and deworming tablets to school-going adolescents, while the Ministry of Women and Child Development is responsible for reaching out-of-school adolescent girls, using existing community-based delivery platform of *anganwadi* centres (village nutrition posts). In 2017, the programme expanded to *ashramshalas* (residential schools for tribal children) across seven states, through funds earmarked by the Tribal Welfare Department.

With UNICEF support in 2017, the fifth year of implementation, all states took steps to ensure the sustainability of the programme, including allocating financial resources for supplies, conducting training and carrying out state-level reviews. In addition, a set of key programme indicators was included in the routine reporting systems of both health and education ministries to monitor programme performance. Close coordination between government ministries, facilitated by UNICEF, has been the foundation of successful programme scale-up.

Innovative strategies have been used at state level to strengthen the programme, with technical support from UNICEF. Odisha State developed a weekly SMS-based reporting system, broadcasting audio, video and other education and communication materials to sensitize adolescents. In Madhya Pradesh, '*Lallima*', a state-wide programme, was launched for 7.4 million adolescent girls, integrating social mobilization and interpersonal counselling, community theatres, distribution of iron and folic acid tablets, deworming and menstrual hygiene management. In Upper Assam division, UNICEF implemented adolescent programming in 63 tea gardens, reaching girls in 298 *anganwadi* centres with iron and folic acid supplementation, and nutrition and health education.

In a collaboration between UNICEF's nutrition and child protection sectors, adolescent nutrition interventions were integrated into adolescent empowerment programmes in seven states. UNICEF also worked to integrate WIFS into other adolescent programmes, including the midday meal scheme (a school-based feeding programme).

UNICEF also worked with states to address bottlenecks, such as in Bihar, where supply shortages were a barrier in 2017. While India has been more successful than many countries in reaching out-of-school girls, this remains an ongoing challenge, and is responsible for the delays in reaching all adolescents in need. In addition, weak monitoring and poor community involvement have been identified as bottlenecks.

To address some of these challenges, India's Ministry of Health is launching the 'Anaemia-Free India 2018–2022' initiative, which includes operational guidelines for states and requires them to: set yearly targets; improve coverage through special communications and a monitoring system; integrate programme reporting within the routine information and reporting systems of allied ministries; and systematize stock-out warning systems and special strategies for vulnerable areas.

Improving iodine status through salt iodization

Salt iodization, where salt is fortified with iodine, is the most effective strategy for eliminating iodine deficiency disorders and protecting children's brain development. UNICEF has been a global leader in salt iodization programmes for more than 25 years, and this work has made important contributions to preventing iodine deficiency in vulnerable populations. Globally, more than 86 per cent of households consumed iodized salt in 2017 and only 15 UNICEF programme countries are considered iodine deficient (*Figure 8*).[44]

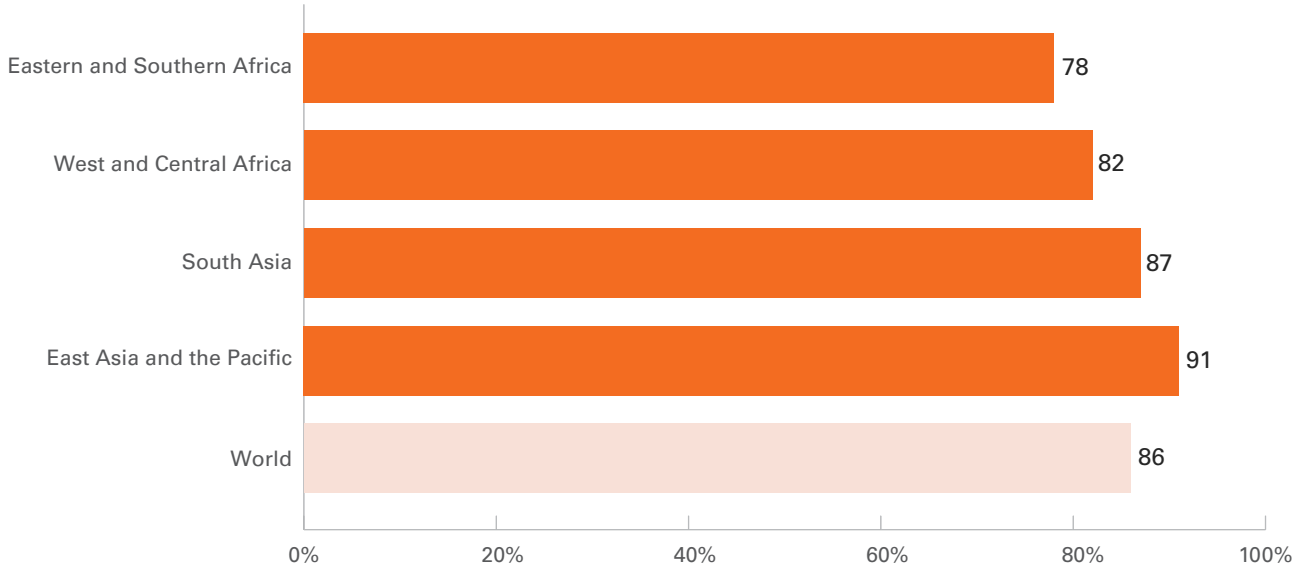
UNICEF supports national governments by developing programme guidance, strengthening the policy environment for salt iodization and engaging with the salt industry. During the strategic plan period, UNICEF aimed to support at least 25 countries in achieving at least 90 per cent of households consuming iodized salt. In 2017, twenty-seven countries were meeting this objective, thus exceeding the target (P4.2). In 2017, UNICEF updated its global iodized salt database to include disaggregated data on urban and rural differentials, wealth quintiles and other indicators of equity, making an important contribution to the monitoring of salt iodization programmes worldwide.[45]

In 2017, UNICEF continued to provide support to strengthen national policy frameworks, such as in the Syrian Arab Republic, where UNICEF provided technical assistance to develop the National Iodine Deficiency Disorders policy.

UNICEF also helped revise the country's micronutrient deficiency guidelines to comprehensively address the problem of iodine deficiency disorders and other micronutrient deficiencies. For salt iodization legislation to be most effective, an active coordination body convening all stakeholders – including government, industry and civil society – is critical. Of 90 reporting countries, 68 had established a national coordination body (up from 61 the previous year), yet only 20 of these were classified as effective (P4.c.4).

UNICEF has a longstanding partnership with the United States Agency for International Development (USAID) to advance universal salt iodization and control iodine deficiency disorders, and this partnership has also been catalytic in funding evidence generation work at the global level. In Cambodia, advocacy efforts with key line ministries and departments led to the revision and endorsement of the national legislation, Sub-decree 69, which spells out the process of certification and factory visits for inspection. The Government of Cambodia also introduced digital technology to monitor salt production sites. A web application was developed whereby mobile phones are used to capture data on iodization status at production and market sites. This has improved transparency in monitoring systems and strengthened quality control. Similarly, in Tajikistan, UNICEF advocacy led to the formation of a technical working group on micronutrients, under the Food Safety Council, which will work towards establishing national and

FIGURE 8: Percentage of households consuming salt with any iodine, by UNICEF region[46]



regional coalitions and strengthening licensing and inspection systems to ensure better availability of adequately iodized salt. UNICEF and partners also documented the success made on the elimination of iodine deficiency disorders in the Americas in a 2017 journal article.[47]

UNICEF strives to control iodine deficiency disorders by fostering partnerships, strengthening national salt legislation and enforcement, and improving quality assurance mechanisms for salt iodization. In the United Republic of Tanzania, UNICEF supported the government through funding from USAID in achieving the salt iodization targets set forth in its national action plan by increasing the number of salt producers trained in salt iodization techniques in Lindi, Mtwara and Pemba from 159 in 2016 to 200 in 2017. UNICEF identified limited technology and the poor capacities of salt producers as key bottlenecks to achieving the targets set; in 2018, UNICEF will strengthen monitoring and surveillance systems by working closely with the Ministry of Health, undertaking capacity-building initiatives to equip the salt producers with skills for improving salt quality.

Strengthening policies and standards for food fortification

National policies mandating the mass fortification of staple grains and other industrially produced foods are effective in safeguarding populations from micronutrient deficiencies. UNICEF, along with global partnerships such as the Food Fortification Initiative, advocates for governments to enact such legislation and builds the implementation capacities of governments and the food industry. The number of countries with legislation to mandate staple cereal fortification (of at least one industrially milled grain) increased from 78 at baseline to 82 countries in 2017, falling short of the target of 90 countries (P4.c.5).[48]

UNICEF supported the development of the Government of Ethiopia's Food and Nutrition Policy and Food Fortification Standards, which together set the legal and policy framework for improving food safety and quality in the country. Thanks to the policy advocacy by UNICEF and its nutrition partners, the Government of Ethiopia established a National Nutrition Council under the deputy prime minister to enhance multisectoral accountability around food fortification. In 2018, UNICEF Ethiopia will provide capacity-building support to line ministries on the enforcement of the Food Fortification Standards to ensure that high-level political commitment is implemented and sustained in practice.

In 2017, UNICEF and the Global Alliance for Improved Nutrition (GAIN) co-organized a multi-country policy advocacy summit on flour fortification in Almaty, Kazakhstan, where the regional system and policy capacity for flour fortification were reviewed and policymakers from eight Central Asian and Caucasus countries, as well as Afghanistan, Mongolia and Pakistan, were sensitized on the importance of quality control in flour fortification programmes.

CHALLENGES, REFLECTIONS AND FUTURE DIRECTIONS

UNICEF learned some important lessons in 2017 that will help shape its future work in this programme area. The phase out of polio NIDs campaigns, which had historically been effective in reaching vulnerable populations, has challenged the sustainability of VAS delivery. While the scale-back of NIDs was not a surprise, planning for other delivery options has proven challenging as the existence of NIDs in a country tends to disrupt planning for more routine services into which VAS could be integrated.[49,50] While some countries have had success using twice-yearly 'Child Health Events' as an alternative for delivering VAS, there has been mixed success in integrating the planning and implementation of these campaigns into health systems to ensure sustainability.

An added challenge is that already fragile health systems may now be tasked with the additional work of delivering VAS. However, country experiences show that routine approaches, such as those used by immunization programmes, can be effective in reaching communities in greatest need and sustaining VAS coverage over the long term. Some countries have increased VAS coverage by institutionalizing a routine health contact at 6 months of age to deliver VAS and other high-impact interventions. As countries transition to new modes of delivery, it will be important to closely track VAS coverage using under-five mortality rates to identify the countries in greatest need. Any efforts to scale back national VAS should be underpinned by a careful estimation of the underlying levels of vitamin A deficiency and an evaluation of the coverage of other vitamin A deficiency control measures.[51]

While policies and programmes to improve adolescent nutrition and well-being are improving, they remain insufficient in many countries and only a few are successfully reaching out-of-school adolescents. There are also very few countries looking at adolescent nutrition beyond iron and folic acid supplementation, and greater efforts are needed to highlight the impact of micronutrient deficiencies on learning outcomes and cognitive development, making clear the value of investing in adolescent nutrition. Given its multisectoral reach and programme experience, particularly in South Asia, UNICEF is best placed to lead countries in achieving results in this area. In preparation for the next strategic plan (2018–2021), UNICEF is identifying gaps and areas in need of urgent attention, and developing an adolescent nutrition strategy and programme tools. As part of this work, UNICEF will look at ways to better leverage schools as a delivery platform, including by mapping school-based nutrition actions and developing a nutrition-in-schools package.

Micronutrient supplementation and fortification programmes are some of the lowest-cost and highest-impact interventions in human nutrition and welfare – and investments in this programme area have supported ground-breaking public health achievements. As UNICEF refines its focus, flexible funding will be critical to providing leadership on emerging areas, while continuing to deliver results to the children in greatest need.

A UNICEF nutritionist screens a child for malnutrition in Ain Issa camp, north-eastern Syrian Arab Republic.

Programme Area 3: Treatment and care for children with severe acute malnutrition and nutrition in emergencies

STRENGTHENING SYSTEMS, SAVING LIVES

When efforts to prevent malnutrition fail, undernourished children – wherever they live – need urgent treatment and care to survive. The treatment of children with SAM involves a combination of routine medication, therapeutic foods and individualized care. Most children can be treated by their families, within their own homes and communities, using ready-to-use therapeutic foods (RUTF).

The care of children suffering from severe wasting – the most frequent form of SAM – is a critical part of UNICEF's work during emergencies and is often associated with populations living in fragile contexts. Globally, however, most children suffering from SAM live in non-emergency contexts, in settings characterized by poverty, limited access to nutritious foods and drinking water, poor feeding practices and cyclical infections, and driven by weak health, food and social safety net systems.

Resources to treat the immense number of children with SAM in these contexts are notoriously limited, compared with the funding available to treat SAM in emergencies. This gap in resources and commitment to prevention has left an alarming 17 million children globally still affected by severe wasting, with less than 20 per cent of them accessing the care they need to survive. UNICEF provides support to governments and partners in scaling up therapeutic treatment and care for children with SAM, in both non-emergency and emergency contexts, and from facility to community level. To ensure that SAM is recognized as a public health priority, UNICEF supports global, regional and country efforts to integrate the care of children with SAM into national health systems and strengthens the delivery of essential supplies to the children most in need.

Countries faced pressing nutrition challenges in 2017, as the number of emergencies continued to rise. Protracted conflicts, natural disasters and devastating food insecurity gripped communities around the world, threatening lives and livelihoods. Emergencies and humanitarian crises are often characterized by limited access to safe food and clean water, as well as disruptions to basic health and nutrition services. A timely, coordinated response is critical to prevent malnutrition and provide life-saving treatment when prevention fails, especially for the most vulnerable children.

Guided by its Core Commitments for Children (CCCs) in humanitarian action, UNICEF's foremost priorities during emergencies are to prevent avoidable deaths, promote child growth and survival, and safeguard the nutrition status of children and women. To protect children's right to nutrition in emergencies, UNICEF and its partners work to establish effective leadership; undertake timely nutrition assessments; identify and treat children suffering from SAM; provide fortified foods and supplements to prevent vitamin

and other nutrient deficiencies; and protect and promote breastfeeding. These interventions ensure that children not only survive an emergency but go on to live healthy and productive lives.

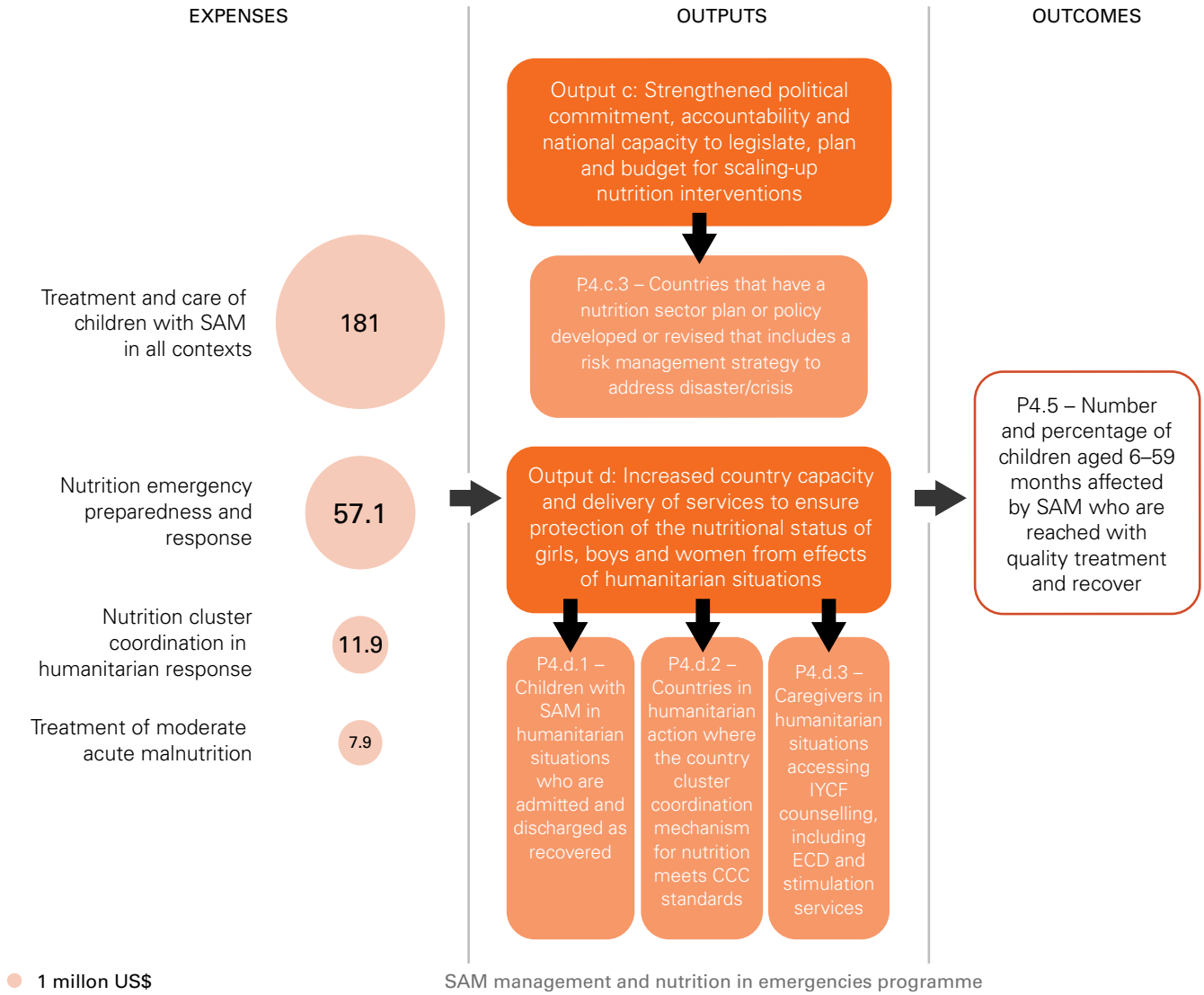
UNICEF delivered emergency nutrition services to children and women in 66 countries in crisis in 2017. UNICEF supports governments in planning and preparing for emergencies, including by developing risk-informed programmes that are poised to scale up and scale down in relation to needs when emergencies strike. Many countries cycle in and out of emergencies, even at subnational levels, and bridging the humanitarian–development divide is critical to reducing vulnerabilities, managing risks and building resilience.

RESULTS CHAIN FOR THE CARE OF SEVERE ACUTE MALNUTRITION AND NUTRITION IN EMERGENCIES

The results chain for the care and treatment of children with SAM and nutrition in emergencies outlines the linkages between programme spending, key interventions and progress on the UNICEF strategic plan output and outcome indicators (*see Figure 9*). Full data on each programme indicator are presented in the pages that follow and in Annex 1.

In 2017, US$258 million was earmarked for Programme Area 3, an increase from 2016, when expenses totalled US$232 million. The bulk of expenditures in this programme

FIGURE 9: Results chain for the care of severe acute malnutrition and nutrition in emergencies



Note: UNICEF provided support to moderate acute malnutrition (MAM) treatment under special circumstances in 10 countries, ranging from medical supplies to capacity-building to supply provision.

area were for the treatment of SAM, including spending on supplies (most notably RUTF, for which UNICEF plays the largest role globally in facilitating access to supplies at country level), as well as direct service delivery in both emergency and non-emergency contexts. From 2016 to 2017, the procurement of RUTF increased by more than 58 per cent, with more than half of it sourced from programme countries. This is in line with the UNICEF supply division's strategic objective to increase the sourcing of RUTF from programme countries during the 2014–2017 strategic plan.

OUTPUTS AND RESULTS IN 2017

Delivering life-saving treatment and care

Children with SAM need urgent treatment and care to survive and thrive; supporting governments and partners in delivering these services is central to UNICEF's mandate. In 2017, UNICEF supported the scale-up of services to treat and care for children with SAM in both development and emergency contexts. With UNICEF support, more children with SAM were reached in 2017 than ever before. The annual number of children treated for SAM increased from 3.2 million in 2014 to 4 million in 2017, achieving the strategic plan target (P4.5). In total, over the four-year strategic plan period, more than 14.9 million children with SAM were provided with life-saving treatment and care in all contexts.

Hunger and undernutrition, including the plight of children with SAM, rightly capture headlines during emergencies; but there are also millions of children affected by SAM in non-emergency contexts, even in middle-income countries. UNICEF is working to provide better treatment and care to children suffering from SAM in these settings, despite limited resources. In Cambodia, for example, the proportion of health facilities in the north-east providing services to treat children with SAM increased from just below one quarter to more than 100 per cent of targeted health facilities by mid-2017 (36 facilities compared with the target of 35). This was made possible by UNICEF financial and technical support to the Ministry of Health, used for capacity-building for identification and treatment, as well as mass screening within communities. In 2016 to 2017, approximately 3,570 children with SAM were treated in the north-east (over the 11,350 children treated nationally). Between 2013 and 2017, the number of children benefiting from at least two follow-up visits after they recovered increased from 54 per cent to 77 per cent. Over the past two years, the scale-up of services to treat children with SAM alongside other services to prevent malnutrition have helped reduce the prevalence of wasting in targeted districts of Kratié Province, from 27 per cent to 13 per cent in the poorest households and from 17 per cent to 5 per cent in the richest households.

The integration of SAM screening with various health and nutrition services can reduce costs and improve programme sustainability. To ensure a continuum of care and to strengthen health system resilience in Ethiopia, UNICEF and WFP advocated for the integration of care for children with moderate acute malnutrition (MAM), formerly handled by Ethiopia's National Disaster Risk Management Commission, into routine health services. In Mali, UNICEF supported a study of the integration of SAM screening into malaria campaigns, which found it to be an effective means of strengthening the ownership of SAM treatment by health systems and communities.

Systems strengthening is part of effective development programming and can improve access to treatment and care services for children with SAM. Better alignment between humanitarian and development programming can also help countries anticipate stresses and shocks and ensure that treatment services are ready to scale up as needed. In Burkina Faso, UNICEF worked with the government to strengthen the supply chain for RUTF and integrate the treatment and care of children with SAM within the health system to improve programme sustainability. In contrast, when the Rohingya refugee crisis began in Bangladesh, national protocols for outpatient care allowing the use of imported RUTF had not been pre-established, making it more challenging to mobilize a response at scale. UNICEF and partners advocated for RUTF to be used as part of the response and developed interim treatment protocols to care for child refugees suffering from SAM.

Mobilizing action to put SAM on the global agenda

Globally, the gap between the estimated number of children suffering from SAM annually and the number of children who are able to access treatment and care each year remains unacceptably wide, despite the scale-up of services in many countries. This is due in part, to the challenge of communicating that SAM is not only a consequence of emergencies, but an ongoing development challenge in many countries – and thus a critical investment. The discrepancy between the number of children affected by SAM and access to treatment and care is highest in East Asia and the Pacific and South Asia. In contrast, most countries with services to provide treatment and care for children with SAM at scale are in West and Central Africa and Eastern and Southern Africa.[52]

To catalyse global action on this alarming situation, UNICEF, DFID, the European Commission, Action Against Hunger, the Children's Investment Fund Foundation and USAID are leading the No Wasted Lives coalition, with the aim of treating 6 million children with SAM annually by 2020. First launched in 2016, No Wasted Lives seeks to make SAM a political and public health priority, identify and share effective ways to prevent and treat SAM, mobilize resources to treat more children in urgent need, and

maximize the effectiveness of current spending. Most recently joined by WFP, No Wasted Lives is contextualizing its focus of SAM in the broader context of a continuum of care for acute malnutrition.

As part the No Wasted Lives coalition, UNICEF is working to investigate innovative financing mechanisms, convene a donor forum to unlock new funding channels, and advocate for the care of children with SAM to be included in wider non-emergency health funding mechanisms. In 2017, UNICEF worked with the coalition's Council on Research and Technical Advice on Severe Acute Malnutrition (CORTASAM) to consolidate and establish global research priorities to facilitate a continuous conversation around improvements in detection, treatment and care. Harnessing the research community's support will be critical to accelerating scale-up and addressing the most critical gaps in the evidence base for both applied research and implementation science.

A plateauing in the number of children admitted for treatment of SAM was identified in Eastern and Southern Africa and West and Central Africa in recent years. In 2017, UNICEF worked to identify bottlenecks to the scale-up of treatment services, and to determine how existing services could be better sustained. Two 3-day regional consultations[53,54] were organized with UNICEF and Ministries of Health in the regions to examine specific barriers and solutions. During the preparatory phase, a country scoping exercise[55] was commissioned by UNICEF in both regions to inform the workshop agenda, and a separate in-depth analysis of existing data was undertaken through No Wasted Lives for both regions. Key themes across both regions included the limited prioritization of SAM care within health systems, the lack of sustainable funding (including domestic resources), and the lack of access to services for early detection, treatment and care at the community level. The outcomes of the consultations are being used to direct the investments of the No Wasted Lives coalition and to inform UNICEF's strategic direction to programming in these regions for 2018 and beyond.

Continuing its global advocacy for prioritizing access to services for early detection, treatment and care of SAM, UNICEF and the South Asian Association for Regional Cooperation (SAARC) held a regional conference on scaling up care for children with severe wasting in South Asia in May 2017. The conference was a landmark event, bringing together governments, academics, United Nations partners and civil society organizations from countries across the region for the first time in relation to the provision of treatment and care for children with SAM. The conference mobilized regional commitments, helped countries identify 10 key actions for accelerating progress, and facilitated the development of country action plans, which will be critical to guiding future policy and programming. The 10 key actions were subsequently endorsed at the Sixth Annual Health Ministers Meeting in Colombo in July 2017, laying the foundation for continued expansion of services to detect, treat and care for children with SAM in the region.

To illustrate UNICEF's comparative advantage in scaling up care for children with SAM to donors and partners, value propositions were developed for the Eastern and Southern Africa, South Asia, and the West and Central Africa regions.

Strengthening evidence and guidance to improve treatment and care for children with SAM

UNICEF conducts research and generates evidence to improve the care of children with SAM in all contexts. UNICEF also works with normative bodies to shape updated guidance, in addition to generating interim operational guidance where needed to address emerging issues related to the treatment of SAM. In 2017, UNICEF and WFP disseminated Interim Operational Guidance for Community-Based Management of Acute Malnutrition in Exceptional Circumstances,[56] which was intended to address shortfalls in the continuum of care for acute malnutrition in emergencies.

SAM is an acute condition and affected children may recover or die within a short time frame. This means that prevalence data from surveys generated at one point in time can fail to detect children who develop SAM during the year, thus underestimating the number of children affected. In an effort to improve methods to generate programming estimates of the numbers of children to be reached with care and treatment for SAM, UNICEF, Harvard University and Action Against Hunger instituted an independent technical advisory group and initiated data analysis to expand the evidence base on SAM incidence.[57] In 2017, key stakeholders convened to discuss progress, data quality and the implications of using incidence correction factors in programmes and policies at national and global levels. The research is ongoing with results and guidance expected in September 2018.

Fostering links between SAM and HIV screening and management

In countries with a high burden of HIV, many children with SAM are also HIV-positive. For these children, recovery depends largely on whether the child is screened and identified as having HIV and provided with antiretroviral therapy along with treatment and care for SAM. According to global guidance, HIV screening should be integrated within services to treat children for SAM; however, this is not yet standard practice in many settings with high HIV prevalence, and UNICEF is working to strengthen these linkages. In Guinea-Bissau, for example, UNICEF supported the integration of HIV testing within nutrition programmes by equipping nutrition rehabilitation centres with HIV test kits to ensure that children with SAM were systematically screened for HIV during treatment.

UNICEF is working to build the capacities of health workers to better link SAM and HIV screening. In Malawi, UNICEF supported in-service training on the integrated HIV and

nutrition approach, and carried out nutritional screening and assessments through the Mothers to Mothers organization in Chikwawa and Mangochi districts. Across all 123 outpatient therapeutic programmes providing treatment and care for children with SAM across the country, 89 per cent of children were tested for HIV and 90 per cent of children in need received antiretroviral therapy, contributing to a decline in the number of children dying from SAM in the country. Malawi's new guidelines on integrated HIV services, to be released in 2018, recommend that all children be screened for nutrition problems in the context of HIV. In Zimbabwe, UNICEF supported capacity-building training for nutrition managers on integrating HIV screening into treatment services for children with SAM. Integrated nutrition and HIV guidelines were also produced, which are expected to improve HIV testing for malnourished children.

Strengthening emergency preparedness and response

Emergencies can strike at any time, and UNICEF helps governments plan for them by putting the right policies and strategies in place ahead of time – and securing the human resources needed to scale up the response when needed. By the end of 2017, sixty-five countries had incorporated an emergency/risk management strategy into their nutrition plan or policy, a small increase from 64 countries in 2016 (P4.c.3). During Kenya's 2017 drought, for example, UNICEF helped develop evidence-based nutrition response plans for affected counties, demonstrating how investments in systems strengthening translate into tangible results on the ground (*see Case Study 5*). In Ethiopia, UNICEF provided technical guidance for developing preparedness and response plans for all regions and strengthened government capacity for planning and coordination, equipping the country to respond to nutrition emergencies in four regions.

Tracking nutrition information is vital to emergency response, and UNICEF supports governments in monitoring and collecting national and subnational data on nutrition to inform critical decisions before, during and after a crisis. In Malawi, UNICEF provided technical and financial support to conduct a nutrition Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey in all seven livelihood zones in the country in May 2017, which showed an improvement in the nutrition situation over 2016. Drawing on the survey results, UNICEF helped realign nutrition emergency response plans and secure the funding needed to continue delivering emergency nutrition programming in all 28 districts. In Somalia, UNICEF commissioned a real-time evaluation of its pre-famine emergency response. The evaluation found that UNICEF met targets and saved many lives through effectively mobilizing donor resources, delivering supplies through established supply hubs, and supporting implementation at scale. Some key lessons were learned about the need to increasingly focus on resilience-building and improve feedback to communities.

No single agency can meet all the needs of a population during an emergency, thus partnerships are indispensable to any effective emergency response. In 2017, UNICEF and WFP recommitted themselves to their long-standing partnership to improve nutrition outcomes for children affected by humanitarian crises, including through a meeting of regional and headquarters staff to identify areas of improvement around nutrition information and situation analysis, care for acute malnutrition, IYCF in emergencies and mobilizing nutrition-sensitive inputs from respective agencies. In 2017, UNICEF joined the Integrated Phase Classification (IPC) Food Security and Nutrition Steering Committee and Technical Advisory Group, and continued participating in the IPC Nutrition Working Group. The IPC process provides countries with a standardized approach to nutrition situation analysis in emergency contexts, and the 2017 focus was on harmonizing the food security and nutrition analysis procedures.

Coordination to strengthen systems and save lives

During emergencies, coordination is essential to delivering a response that is tailored to the situation and builds from existing capacities. UNICEF is mandated as Cluster Lead Agency for Nutrition, working to promote coordinated, timely and effective nutrition emergency response at both national and subnational levels. Cluster coordination strengthens emergency response by supporting needs assessments, identifying gaps and delivering urgent services to address them. The cluster also builds national capacity, provides oversight to ensure the response adheres to international standards, and monitors and evaluates the response and its coordination. In countries where the nutrition cluster has been activated, UNICEF leads and engages partners, ensuring that coordination mechanisms are established and supported, serving as a first point of contact for government and acting as a provider of last resort. In this role, UNICEF provided coordination support in 58 countries. Of all 13 formal nutrition clusters, 100 per cent met the CCC standards for coordination, achieving the strategic plan target (P4.d.2).

UNICEF continued to convene more than 40 partner members of the Global Nutrition Cluster (GNC) with the goal of galvanizing partnerships and resources to improve coordination and the quality of the responses. In 2017, the GNC supported the coordination of life-saving nutrition in emergencies interventions for more than 517 million people considered to be in need of emergency nutrition services around the world, covering 23 Humanitarian Response Plans and 4 Refugee Response Plans. In 2017, UNICEF and GNC partners consolidated the foundation for a mechanism to provide technical leadership and support to governments, country cluster coordination forums and partners, and for facilitating communication between country, regional and global levels. Pressing technical questions and support needs often arise from countries, and it is important for UNICEF as the Cluster

Lead Agency to respond swiftly, be it in terms of providing technical advice, generating interim operational guidance or accessing technical expertise. UNICEF has thus established a global platform to tackle these unresolved questions and respond to technical support needs in humanitarian contexts. The platform has been endorsed by all cluster partners and will be put in place in the first quarter of 2018.

UNICEF continued to be a leader in issuing global guidance on nutrition in emergencies in 2017, collaborating with regional offices and GNC partners to develop a toolkit for action on fulfilling the Nutrition CCCs.[58] UNICEF also held regional preparedness and response workshops in Europe and Central Asia, and Eastern and Southern Africa, bringing together 18 countries; the learning from the workshops will contribute to developing an updated global training package on humanitarian action.

CASE STUDY 5: KENYA: SYSTEMS STRENGTHENING TO COORDINATE AN EFFECTIVE DROUGHT RESPONSE

When Kenya experienced a severe drought in 2017, UNICEF supported the Ministry of Health and the National Drought Management Authority in ensuring a timely and effective response, building on previous efforts to strengthen systems and build resilience within vulnerable counties. With the efforts of UNICEF and partners, the Government of Kenya mitigated the unnecessary loss of life during the worst drought since 2011 – a success that was aided by investing in strategic partnerships, building national and county capacities using embedded nutrition staff, and generating timely evidence to support emergency response between 2011 and 2017. Another critical factor was UNICEF advocacy to mobilize greater resources, which secured US$18 million through global fundraising, exceeding the initial target of US$15.5 million.

UNICEF supported twice annual nutrition assessments in the most affected counties to inform the emergency response and mobilized existing partnerships at the county level to scale up outreach screening and treatment for SAM. In addition to its collaboration with the Ministry of Health and the National Drought Management Authority, UNICEF forged strategic partnerships with WFP, the Kenya Red Cross Society, 13 implementing partners, and donors. An extensive network of UNICEF county-level nutrition officers supported subnational coordination efforts through the development of evidence-informed, county-specific nutrition response plans, including strategies to address post-election risks, as political uncertainty further complicated the drought response.

At national level, UNICEF embedded a nutrition sector coordinator within the Ministry of Health who supported the development of a costed sector response plan that was key in leveraging US$4.5 million from domestic resources for the nutrition sector response. Further, the sector coordinator and an emergency specialist provided support to develop key guidelines on outreach activities and screening for partners.

UNICEF has been integrating the delivery of supplies to treat children with SAM through the national supply system, which has allowed RUTF and therapeutic milks to be delivered directly to facilities since 2015, using a phased approach. The number of counties integrated through the supply system increased from 5 in 2016 to 15 in 2017, ensuring an uninterrupted delivery of life-saving supplies to the children most in need – despite the increased demand. A second pipeline was established using supplies in the eight regional depots of the Kenya Red Cross, and a third buffer stock in high-needs counties was provided at sub-county level to ensure no stock-outs were experienced. As a result, care for children with SAM was made available in at least 80 per cent of health facilities across the 23 arid and semi-arid land counties. By the end of the year, more than 80,580 children with SAM had been admitted for treatment and care (102 per cent of the target), significantly surpassing both the 2015 and 2016 annual admission figures.[59]

In addition to the screening and management of SAM, country response plans included integrated outreach services to manage common childhood illnesses and provide immunization, VAS, deworming, reproductive health services, and health messaging. Outreach services were bolstered by strengthening UNICEF's 'surge approach' (i.e., providing additional emergency staff and resources) in 153 health facilities in the most affected counties, which strengthened the health system's ability to adapt and effectively manage the increase in the number of children suffering from SAM.

An unanticipated five-month nurses' strike emerged in 2017 as a major bottleneck to service delivery at facility level. UNICEF, in collaboration with implementing partners, addressed this challenge by using the Kenya Red Cross partnership to fill staffing gaps and expand outreach services in the most affected areas. UNICEF also engaged with county leaders to identify solutions, and generated evidence to address the strike's impact on reaching the most vulnerable children, which was used for advocacy with the national government. UNICEF assessed capacity gaps within each county and developed action plans to address human resource constraints within facilities and community outreach services.

The 2017 drought response in Kenya offered important lessons in planning, preparedness and responding with equity. Efforts to fill capacity gaps and improve supply chain integration were critical for providing outreach services to the most vulnerable populations despite the nurses' strike and the deteriorating nutrition situation. In addition, UNICEF's frequent interaction with national institutions through embedded staff also influenced national and local planning processes.

The effective nutrition sector response in 2017 clearly demonstrated a return on the investments made by UNICEF in the nutrition sector in Kenya since 2011. Significant and multi-year investments in coordination at national and subnational levels, capacity development in service delivery, supply chain integration, nutrition information and early warning, and the implementation of the surge model have been key to increasing government accountability and capacity to lead the response in times of crisis. These successes reflect the critical long-term efforts of UNICEF and national partners to develop risk-informed programmes and build resilience in vulnerable counties.

A mother carries her child as she walks through drought-stricken Badanrero village in Moyale, Marsabit County, Kenya.

A mother breastfeeds her newborn baby in Al Saba Hospital, Juba, South Sudan.

Preventing undernutrition in emergencies

During emergencies, interventions to protect IYCF practices and deliver micronutrient supplements and fortified foods to women and children become even more important. These interventions are essential for preventing undernutrition and keeping children strong and resilient in the face of crisis.

UNICEF provides IYCF counselling during emergencies and establishes safe spaces for caregivers to feed and care for their children. With UNICEF support in 2017, nearly 6 million caregivers (90 per cent of those targeted) received information, counselling and support for IYCF in situations where there was a humanitarian crisis. Integrating early childhood stimulation and development as part of IYCF counselling in humanitarian situations has been a challenge, however: the number of caregivers benefiting from combined interventions declined from 793,390 in 2016 to 656,819 in 2017, falling below the expected target (P4.d.3). Many countries, such as Myanmar, are in the process of drafting ECD strategies and strengthening the ECD component of their IYCF programmes, but these will not be put in place until sometime in 2018. Other countries, such as Ethiopia, noted the challenge of monitoring stimulation as part of IYCF counselling, particularly during emergencies.

Caregivers face important challenges in providing safe and adequate foods for their infants and children during emergencies, and countries need guidance on responding to these needs. With this in mind, UNICEF and the Emergency Nutrition Network co-led the revision of the Infant Feeding in Emergencies Operational Guidance in 2017, disseminating this guidance to 100 countries in preparation for further scale-up in 2018.[60] The guidance was launched during the GNC's October 2017 meeting, attended by all cluster agencies and most nutrition cluster coordinators, thereby equipping them to move into action at scale within their own responses. UNICEF also developed agency specific guidance for the procurement and use of breastmilk substitutes in humanitarian settings, in an effort to regulate the uncontrolled and unethical distribution of infant formula during emergencies.

UNICEF continued capacity-building and awareness-raising on the importance of optimal IYCF practices during emergencies. Together with Save the Children, UNICEF mapped regional capacities for IYCF in emergencies in the Eastern and Southern Africa region and provided guidance on establishing the emergency response framework for IYCF in Kenya, Somalia and South Sudan. In the Syrian Arab Republic, UNICEF collaborated with the Ministry of Health, the Syrian Arab Red Crescent, the Syrian Commission for Family Affairs and other national and international NGOs to train more than 930 health workers on IYCF counselling, allowing them to reach more than 984,000 caregivers with counselling to improve feeding practices. UNICEF also provided support to deliver micronutrient supplements to 2.2 million children and pregnant and lactating women.

CASE STUDY 6: THE NIGER: IMPROVING FEEDING PRACTICES AND DELIVERING LIFE-SAVING CARE

In 2017, the Niger continued to face high levels of acute malnutrition that exceeded emergency thresholds. The ongoing Lake Chad Basin crisis, linked to the armed conflict with Boko Haram in the south-eastern Diffa region bordering Nigeria, further exacerbated the already alarming levels of malnutrition.

As part of the emergency response in Diffa, more than 14,550 children under 5 years of age with SAM were admitted for treatment in outpatient and inpatient facilities, exceeding the target. With UNICEF-supported treatment and care, more than 92 per cent of these children successfully recovered. Monthly screening for acute malnutrition was integrated within the seasonal malarial prophylaxis campaign conducted during the lean season. This innovative approach reached more than 112,850 children aged 6–59 months in Diffa, identifying and referring more than 3,600 children with SAM during this period.

UNICEF also supported VAS and deworming prophylaxis, integrated within vaccination campaigns, as part of the package of emergency nutrition interventions in Diffa. The campaign provided critical protection to vulnerable children, successfully achieving 92 per cent of the programme target for VAS, and 86 per cent of the target for deworming. To promote and protect breastfeeding during the crisis, UNICEF supported community- and facility-based IYCF counselling and support for more than 102,500 infant-mother pairs, including more than 67,340 located in displacement camps.

In its Cluster Lead Agency role, UNICEF provided focused technical and coordination support in Diffa, contributing to important improvements in the nutrition situation of displaced children in that region from the previous year.

The nutrition status of children in Diffa was monitored through an annual SMART survey, which showed higher rates of malnutrition than in 2016, but a significant improvement among children in displacement sites and refugee camps: The prevalence of global acute malnutrition among children in displacement sites had declined, from 13.6 per cent in 2016 to 8.9 per cent in 2017; and in refugee camps, global acute malnutrition had dropped from 12.3 per cent in 2016 to 6 per cent in 2017. About 54 per cent of infants were exclusively breastfed in Diffa, with the highest rate reported in a displacement camp (71 per cent). Refugee and displacement camps also reported the highest prevalence of children eating the minimum acceptable diet, suggesting that the IYCF services were effective in targeting this particularly vulnerable population.

The achievements in emergency nutrition response were facilitated by UNICEF technical assistance in coordination, the provision of supplies and supportive supervision, and the collaboration of NGOs partners supporting day-to-day implementation. In November 2017, UNICEF launched RapidPro in Diffa, an SMS-based technology to facilitate real-time monitoring of children admitted for treatment of SAM and track the status of essential supplies. This real-time data will allow UNICEF and partners to improve planning and better identify and target services to boost coverage in the districts most in need.

The tense security situation in 2017 posed significant access constraints, limiting the expansion of nutrition interventions in remote districts of Diffa where there were no implementing partners. The high turnover of government and NGO staff also posed further challenges for capacity development and sustainability. There is a need to continue strengthening the government's capacity to coordinate and lead nutrition interventions in Diffa, particularly in remote districts where needs are most pressing. UNICEF is planning an in-depth evaluation of its programmes to strengthen capacity and improve evidence-based decision-making as the programme evolves.

Despite the importance of preventive interventions, donor funding in emergencies is often heavily weighted towards the treatment of SAM and supplies. However, support for breastfeeding and complementary feeding also saves countless lives during emergencies, and experiences in the Niger (*see Case Study 6*) and other countries show that investments in this area can yield rapid and sustainable results. In Yemen, UNICEF supported IYCF counselling for more than 870,000 pregnant and lactating women through IYCF corners, outreach activities, mobile teams and community health volunteers. In 2017, an additional 247 IYCF corners were established, raising the total number of operational IYCF corners to 824 or 92 per cent of the planned 900 corners. Nearly 4.7 million children received micronutrient supplements (an increase from 4.1 million children the previous year), while iron and folic acid supplements were delivered to more than 706,150 pregnant and lactating women. With UNICEF support, more than 3.2 million children under 5 years of age were screened for acute malnutrition – an increase from 2 million the previous year – using a nationwide screening campaign integrated with polio NIDs.

Delivering treatment and care to save lives during emergencies

Safeguarding the nutritional status of children and women in emergencies comes first. However, when preventive measures – such as good nutrition, health, food security and WASH services – break down during emergencies, rapid detection, treatment and care for children with SAM is critical.

A number of increasingly complex emergencies occurred throughout the strategic plan period, particularly in 2017, leaving populations on the brink of famine in the Kasai Region of the Democratic Republic of the Congo, north-east Nigeria, Somalia, South Sudan and Yemen. Three million children with SAM were treated in the context of emergency nutrition response in 2017, with 91 per cent of them recovering (P4.d.1).[61]

These achievements in saving lives have been driven by notable scale-up efforts in many of UNICEF's largest country programmes. During the last four years in Nigeria, UNICEF supported community-based care for children with SAM, expanding services to 12 northern states in 2017. The number

A mother cradles her son, who is being treated for acute malnutrition at a UNICEF-supported outpatient therapeutic programme in Baidoa, Somalia.

of local government areas covered by the programme increased from 97 in 2014 to 157 in 2017, exceeding the target of 120 for the programme cycle. Cumulatively, more than 1.72 million children with SAM were reached between 2014 and 2017, including more than 506,000 reached in 2017 alone (98 per cent of the annual target). Of all children with SAM admitted for treatment in 2017, eighty-nine per cent (more than 450,000 children) recovered fully, surpassing national and international standards. To increase programme coverage with equity, UNICEF trained more than 3,000 health staff to treat children with SAM through fixed treatment facilities, outreach sites and mobile clinics established to reach children in remote areas. In addition, 3,500 community nutrition volunteers were trained to screen and refer children with SAM. Despite being home to the largest number of children with SAM, there are fewer treatment services available in Nigeria's north-western states compared with those in the emergency-affected states of the north-east, due to limited funding available for the programme in the non-emergency states. There is an urgent need to close this funding gap if Nigeria is to significantly increase SAM treatment coverage country-wide.

UNICEF continued to scale up therapeutic treatment and care for children with SAM in Afghanistan throughout 2017, where the number of health facilities providing treatment services to children with SAM increased from 926 in 2016 to more than 1,000 by the end of 2017. UNICEF helped deliver life-saving supplies, provided technical support for strategy development, and trained 767 health workers to provide better care for children with SAM. This support helped achieve the target of treating more than 224,930 children with SAM by the end of 2017, with 86 per cent of them recovering fully. A UNICEF-supported bottleneck analysis showed significant improvements in service delivery and coverage from 2015. Access to the programme across different geographic areas improved and the proportion of children accessing care for SAM out of those in need increased from 34 per cent to 54 per cent, with an increase in the proportion of children completing treatment from 25 per cent to 47 per cent. Nationally, the proportion of clinicians and community health supervisors trained to care for children with SAM doubled. With UNICEF's guidance, each of the five regions of Afghanistan developed action plans to remove bottlenecks related to access and service quality, which were integrated into the national nutrition plan.

UNICEF continued to strengthen government capacities to deliver and monitor therapeutic treatment for children with SAM in 2017. In Ethiopia, the number of sites equipped to care for children with SAM rose from about 16,600 in 2016 to more than 18,000 in 2017, and the quality of care that children received remained above international standards, with more than 91 per cent of children recovering. UNICEF facilitated training for more than 8,000 health workers to enhance capacities in SAM treatment and care, and mobile health and nutrition teams delivered an integrated package of nutrition, health and WASH services in hard-to-reach areas in Afar, Oromia and Somali regions.

Amid the rising hunger crisis and challenging access due to conflict and rainy seasons in South Sudan, UNICEF and WFP continued their partnership to provide a continuum of care for acute malnutrition, with UNICEF supporting the treatment of SAM in outpatient therapeutic programmes and WFP supporting the treatment of MAM through targeted supplementary feeding programmes. The partnership enabled joint monitoring of activities in facilities and the provision of technical assistance to the Ministry of Health at national and state levels. Despite the challenging context in the country, UNICEF contributed to a 17 per cent increase in the number of outpatient therapeutic facilities from 629 in 2016 to 736 in 2017. Through UNICEF-supported treatment facilities and outreach sites, nearly 207,000 children under 5 years of age with SAM were admitted for treatment (99 per cent of the target), and nearly 87 per cent of them were discharged as fully recovered. These achievements were facilitated by the pre-positioning of supplies in conflict-affected locations; the increased presence of partners; and improved linkages with the treatment of MAM, which in turn reduced the number of children at risk of deterioration into SAM.

SPOTLIGHT ON INNOVATIONS – TRAINING MOTHERS TO SPOT THE SIGNS OF ACUTE MALNUTRITION

Health and nutrition service delivery often breaks down in emergencies, making it is even more important to strengthen community outreach structures to identify and treat children with SAM. In the Niger, UNICEF initiated a partnership with the Ministry of Health, WFP and the NGO ALIMA, to scale up an approach called 'MUAC-by-mothers'. The approach aims to improve the early identification of children with SAM by training mothers and caregivers to screen children themselves using mid-upper-arm circumference (MUAC) measurements. The initiative targets all families in Maradi, a region with high numbers of children with SAM, reaching approximately 800,000 women. A similar approach is under way in Madagascar, where more than 169,900 mothers are being trained in screening techniques for the early detection and referral of children with acute malnutrition.

Missions to some areas of South Sudan through the rapid response mechanism (RRM) continued to be the best way of reaching women and children in areas made inaccessible due to insecurity and limited access during the rainy season. Following the declaration of famine in January 2017, UNICEF, WFP and partners conducted 51 RRM missions, including four in the most food-insecure locations in Wau, where social services had been suspended due to insecurity and high population displacement. More than 94,550 children were screened for malnutrition as part of these missions, and VAS, deworming and support for IYCF were also provided.

CHALLENGES, REFLECTIONS AND FUTURE DIRECTION

Greater resources and awareness are needed to tackle the high burden of SAM in non-emergency settings. The case of the Niger is illustrative: resources to support sustainable expansion of services to detect and treat SAM in 2017 were derived almost entirely from emergency appeals, yet only 4 per cent of the total number of children affected by SAM were in Diffa, the region in a state of emergency. UNICEF, through the No Wasted Lives coalition, aims to provide critical leadership and to mobilize global commitment to close this gap and ensure that all children in need can access treatment and recover.

In developing its next strategic plan, UNICEF has emphasized the scale-up of early detection and treatment of SAM as part of an integrated package of routine services for children in all contexts. Lessons from the SAM regional consultations and evidence gathered by No Wasted Lives suggest the need to generate learning through implementation science at both policy and programme levels, strengthen the availability and quality of nutrition data for programme planning and monitoring, and increase linkage with preventive interventions both within and beyond nutrition. Technologies that allow for real-time data transmission can help, as can better integration of SAM data within national health information systems. Improving community-based strategies and strengthening human resources capacity through pre-service training on SAM management will also improve the recognition of SAM as a common childhood condition, fostering better ownership and engagement.

The scope and scale of nutrition emergencies continued to grow over the last four years, and in 2017 the needs were greater than ever before. Ongoing humanitarian crises required considerable resources and stretched UNICEF's capacity to respond. Most of the funding allocated to emergencies in 2017 continued to be earmarked for nutrition supplies to treat SAM, which are critical to saving lives. However, there is a concurrent need to boost investments in broader systems strengthening, capacity development and resilience-building to ensure communities can bounce back from crisis. Flexible funding streams would help UNICEF support these goals and sustain development gains even when emergencies strike, build systems in protracted emergencies and promote risk-informed programming and capacity in order to strengthen the humanitarian-development nexus.

Much greater emphasis on prevention is still needed, along with greater investments in interventions that work – such as support for improving breastfeeding and complementary feeding, supplementation and fortification with vitamins and nutrients, access to health services, and a safe and healthy environment. The prevention and treatment of wasting is interconnected with the prevention of stunting – and stunting prevention should also be an active part of emergency response. However, a recent stock-take by the Emergency Nutrition Network revealed that there is no systematic monitoring of stunting trends in emergencies.[62] A further obstacle is the threshold for declaring an emergency, which is based on acute malnutrition data alone, and does not take into account stunting or other indicators. This is the time to redefine nutrition emergencies, to take into account the evolving challenges faced by children and women in fragile contexts and our expanded global evidence base, and to explore updated methods for declaring and acting on nutrition emergencies.

Effective coordination during emergencies is critical and the cluster approach helps ensure fewer gaps and overlap in the services delivered by different partners. Today, however, the GNC is experiencing its largest ever funding shortfall – at a time when the need for effective coordination is particularly critical. In the context of protracted and increasingly complex humanitarian crises, greater investments in coordination capacity are urgently needed.

A young boy sits on his mother's lap in the stabilization centre at Children's Hospital in the city of Multan, Punjab Province, Pakistan.

Programme Area 4: General nutrition

TOWARDS A WELL-NOURISHED WORLD

Good nutrition is the foundation of thriving communities and nations. To foster a generation of well-nourished children, governments need to invest in enabling policies and frameworks that create the conditions where good nutrition can take hold.

Through its general nutrition programme area, UNICEF aims to support countries in this process, including by developing evidence-based policies and strategies, strong partnerships and robust monitoring systems. This work takes place across diverse country contexts, and UNICEF adapts its approaches to respond to national priorities, supporting governments and working closely with communities.

At the global level, UNICEF works with a wide range of partners to build momentum for ending malnutrition in all its forms. In particular, UNICEF's leadership role in the Scaling Up Nutrition (SUN) movement is important in galvanizing national commitments to and investments in maternal and child nutrition.

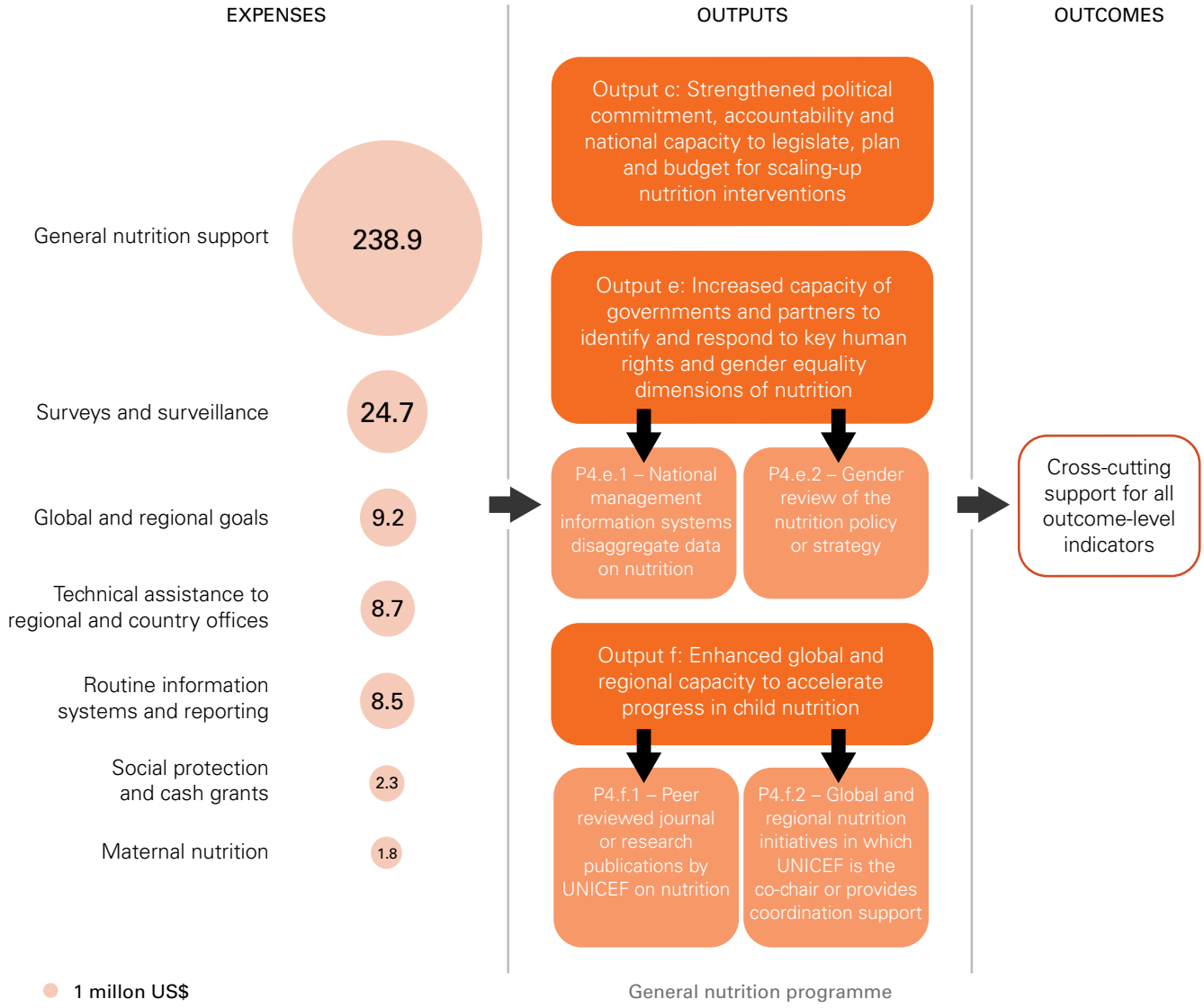
This work is cross-cutting by nature, and thus the resources, outputs and outcomes reported under this programme area support the work of the other three nutrition programme areas. Through its achievements in improving policies, strengthening multisectoral collaboration, forging global partnerships, mobilizing investments in nutrition, improving data and expanding the knowledge base, the general nutrition programme area has paved the way for better results throughout the strategic plan period and beyond.

RESULTS CHAIN FOR GENERAL NUTRITION

The results chain for general nutrition outlines the linkages between programme spending, key interventions and progress on the UNICEF strategic plan output and outcome indicators (*see Figure 10*). The general nutrition programme outputs are linked with results of the other programme areas and strongly support their achievement.

In 2017, US$294 million was spent on the general nutrition programme, an increase from US$225 million the previous year. The largest amount was allotted to 'general nutrition support', which includes service delivery, capacity development and advocacy efforts to improve nutrition policies and programmes.

FIGURE 10: Results chain for general nutrition



OUTPUTS AND RESULTS IN 2017

Strengthening national policies, strategies and plans

UNICEF supports countries in developing strong national policies and strategies, which are essential for fostering an enabling environment for nutrition. National policies and strategies do not improve overnight; this work often takes place over a number of years, involving advocacy at all levels, policy dialogue with key stakeholders, and technical assistance and guidance to governments in turning their commitments into action plans. The number of countries that have a nutrition sector policy or plan developed or revised with UNICEF support increased four-fold over the strategic plan period, from 22 in 2014 to 94 in 2017.

UNICEF continued to provide guidance and support to countries in developing multisectoral nutrition strategies in 2017. In Afghanistan, national capacities are weak and poorly coordinated, and UNICEF has worked for a number of years to strengthen the national framework for nutrition. This advocacy proved successful in 2017 with the launch of the Food Security and Nutrition Agenda, a multisectoral framework bringing together 11 ministries, 4 United Nations agencies, donors, civil society and the business community to improve coordination, increase focus, leverage resources, improve planning and monitoring, and support the SDG targets. In Bangladesh, UNICEF helped finalize the costed National Plan of Action on Nutrition and advocated for establishing the Bangladesh National Nutrition Council to enhance multisectoral governance and accountability for its implementation.

In the Syrian Arab Republic, UNICEF collaborated with the Ministry of Health, WHO, WFP, FAO and national partners to develop a National Nutrition Strategy (2018–2020). Based on a thorough situational analysis, the strategy recommends a multisectoral approach to providing nutrition services and defines the roles and responsibilities of different stakeholders. The strategy will be endorsed at the beginning of 2018 and will provide a road map for future nutrition programming in the country. In Madagascar, UNICEF garnered government support and provided technical assistance to develop a new National Nutrition Action Plan. In 2017, the proportion of Madagascar's domestic budget earmarked for nutrition increased by 1.4 percentage points (from a baseline of 0.28 per cent in 2015 towards a target of 5 per cent in 2019) and the total amount allocated to nutrition rose by 41 per cent between 2016 and 2017, owing in part to UNICEF's concerted advocacy.

Similar support was provided to leverage budgets for nutrition in Kenya, where UNICEF developed a costing tool for use with county nutrition action plans. A nutrition financial tracking tool, also supported by UNICEF, was finalized and rolled out in six counties to help prioritize resources. With these combined approaches, counties are better placed to objectively track nutrition resource allocations and expenditure, and further advocate for nutrition investments across relevant sectors. The county nutrition action plans and their budgets are guided by Kenya's Food and Nutrition Security Policy Implementation Framework, which was developed with UNICEF support in 2017. The framework fosters a coordinated approach and accountability among stakeholders in addressing food and nutrition insecurity in the country.

In the Niger, UNICEF and partners carried out a cost-effectiveness analysis of the interventions included in the country's national multi-sectoral nutrition security action plan to help decision-makers prioritize those most effective in reducing the high rates of malnutrition in the country. The analysis showed that implementing the action plan could reduce under-five mortality and stunting prevalence, but it would be costly and would not decrease the overall number of stunted children due to rapid population growth. In contrast, the combined effects of the action plan and the national family planning strategy could together spark a 33 per cent reduction in the number of stunted children by 2025. The analysis also showed that implementing a package of high-impact nutrition interventions targeted in regions with the highest rates of stunting would yield 16 dollars in economic returns for each dollar invested. The Government of the Niger will use the findings to inform the 2018 action plan launch and will include nutrition and its cross-sectoral linkages for the first time in the country's national economic and social development plan.

In 2017, UNICEF mobilized political commitment and leveraged domestic financial resources for nutrition in Nigeria. UNICEF supported the development of the Nigerian National Policy of Food and Nutrition and related National Strategic Plan of Action for Nutrition, and advocated for states to establish functional committees for food and nutrition. As of 2017, eighteen out of 37 states have developed costed nutrition plans, achieving the planned target. A total of 26 states (96 per cent of the target) have functional state-level food and nutrition committees. UNICEF generated evidence to inform advocacy with government and key stakeholders to support the release of US$2.8 million for nutrition, compared with US$1.2 million in 2016. The long-awaited inauguration of the National Nutrition Council also came into effect as a result of ongoing advocacy by UNICEF and its partners.

Evidence-based planning was critical to supporting the implementation of the national multisectoral nutrition action plan in the United Republic of Tanzania. UNICEF provided technical assistance for regions to produce multisectoral nutrition scorecards; and the proportion of regions producing them increased from 12 per cent in 2015/16 to 73 per cent in 2016/17. The proportion of councils carrying out at least one annual bottleneck analysis of nutrition interventions also increased with UNICEF support, from 79 per cent in 2015/16 to 98 per cent in 2016/17. With the support of UNICEF and partners, average nutrition spending per nutrition council increased from 125 million Tanzanian shillings (TZS) in 2015/16 to TZS147 million in 2016/17, signalling good progress towards the target of TZS400 million by 2021. Limited staff capacity and a lack of available disaggregated nutrition data in most local government authorities was a challenge to implementing both the bottleneck analysis and the scorecard. UNICEF is strengthening the capacities of nutrition officers to improve data collection and analysis.

Mainstreaming gender into nutrition policy and programmes

National nutrition policies and plans should be gender-sensitive and use a rights-based approach to address inequalities. UNICEF works with governments to bring a gender lens to their nutrition programming, including by developing inclusive policies and strategies that tackle the inequalities and discrimination faced by women and girls in accessing good nutrition.

In 2017, twenty-eight countries reported undertaking a gender review of their nutrition policy or strategy in the current national development plan cycle, with UNICEF support (P4.e.2). While this number falls short of the target of 40, it is significant progress from two years earlier, when only 21 countries had undertaken such a review. Many of these reviews indicated a need for greater support to report disaggregated data and results for girls and boys. Upon further reflection, the target for this indicator may have been unrealistic, given that it can take governments up to five years to complete a national development plan cycle, and the nutrition policy would likely not be reviewed every year.

The Government of Pakistan has made important strides in establishing gender-sensitive policies and bringing a gender lens to nutrition information systems. In 2017, UNICEF finalized and piloted the Nutrition Management Information System (NMIS) in Khyber Pakhtunkhwa and Federally Administered Tribal Areas, and trained 145 master trainers to put the new system into action in these areas as well as in Balochistan and Sindh. The NMIS will allow national nutrition problems to be assessed by gender in real time and will inform advocacy for gender-responsive policies, strategies and programming.

Leveraging joint programming for greater impact

Nutrition and WASH programmes are integrated in many contexts, given that poor sanitation and hygiene practices are essential determinants in the cycle of infectious diseases and undernutrition.

In Pakistan, UNICEF continued implementing its nutrition and WASH stunting-reduction programme. In 2017, UNICEF improved the sustainability of the programme's joint monitoring framework; developed a stunting-reduction manual for Lady Health Workers in Sindh; and prepared communication strategies focusing on feeding practices, WASH, health and food security in Punjab and Sindh. Outcomes and field experiences were examined as part of a lessons-learning exercise that was shared with other UNICEF country offices and partners. UNICEF also supported formative research to guide the development of an integrated and gender-responsive WASH and nutrition social and behaviour change communication intervention, which uses participatory dialogue to strengthen mothers' abilities to adopt desired behaviours and garner family support for caregiving.

Many countries have made strides to improve the convergence of nutrition and WASH sectors. In India, the nutrition missions are an important state-level platform, bringing together the nutrition, health and WASH sectors to improve nutrition outcomes. In 2017, West Bengal approved the formation of a state Nutrition Mission and UNICEF continued to support five other state nutrition missions to forge strategic partnerships to scale up actions for improved maternal and child nutrition. In Tamil Nadu, a State Nutrition Alliance, comprised of 20 partners, was formed to strengthen existing mechanisms for convergence and to coordinate state nutrition policy, which was vital to improving coordination among health, nutrition and WASH sectors.

UNICEF also contributed to building national capacities for multisectoral coordination. In Malawi, UNICEF collaborated with World Relief International and the Department of Nutrition, HIV and AIDS to train 1,800 community-based workers in eight target districts to improve their skills in implementing the stunting-reduction programme. In 2017, these workers reached more than 152,200 households (82 per cent) with maternal and child nutrition and WASH interventions. UNICEF and its partners also trained 75 District Nutrition Coordination Committee members in seven districts, including those from health, agriculture, education, social services and local government. With these improved skills, committee members went on to develop multisectoral workplans to address stunting in the seven districts.

The DFID-supported Joint Resilience Project in the Sudan is another example of effective nutrition-WASH integration. This three-year project, a partnership between UNICEF, FAO and WFP, was implemented from September 2014 to August 2017 and aimed to build resilience by addressing the effects of flood and drought shocks on the health and nutrition status of women and children in four localities in Kassala State, eastern Sudan. The affected populations' nutritional status improved by implementing evidence-based direct nutrition interventions in combination with health, WASH, agriculture and livelihood interventions. The four localities targeted by the joint intervention reported fewer cases of diarrhoea, with the project partially contributing to this important result. Between 2015 and 2016, stunting among children under 2 years of age dropped from 67 per cent to 57 per cent; anaemia among children aged 6–59 months declined from 73 per cent to 69 per cent, and anaemia among pregnant women decreased from 43 per cent to 32 per cent. Treatment for diarrhoea increased markedly from 64 per cent to 84 per cent, while the number of cases where caregivers did not seek health services when their children were ill dropped from 14 per cent to 3 per cent. The use of soap for hand washing increased from 58 per cent to 72 per cent, and 13,842 people gained access to functional water facilities, exceeding the target of 13,306 people.

Partnerships and the power of SUN

Collaboration and partnerships are key vehicles for accelerating progress on maternal and child nutrition, and these are tracked as indicators in the strategic plan. In 2017, UNICEF remained the chair, coordination committee member or board member of 12 global nutrition initiatives, exceeding the target of 10 (P4.f.2).

The SUN movement continues to mobilize the global nutrition community with its support to nationally driven efforts to end malnutrition, and UNICEF continued to play a leading role in SUN initiatives at country, regional and global levels. UNICEF Executive Director continued to chair the SUN Movement Lead Group and the UNICEF chief of nutrition served on the Steering Committee of the United Nations Network for SUN and the United Nations Standing Committee on Nutrition. The SUN movement is also a founding partner of the Deliver for Good initiative, a global campaign that applies a gender lens to the SDGs and promotes investments in girls and women to help achieve them.

The SUN Global Gathering is the flagship biennial event bringing together all SUN government focal points and representatives from the SUN networks. In 2017, for the

first time, this was held in a SUN country, hosted by the Government of Côte d'Ivoire, where stakeholders convened to take stock of progress and challenges, share innovations and learn what is helping to reduce malnutrition across all SUN countries. Many SUN countries have appointed high-level nutrition champions, and this leadership is proving invaluable for sustaining political commitment to nutrition.

The number of SUN members increased steadily over the strategic plan period, from 48 countries in 2014 to 60 countries and three states of India in 2017, with the Central African Republic, Gabon and Afghanistan being the movement's newest members. UNICEF, together with FAO, WFP and WHO, facilitated the Central African Republic's membership by supporting the government in establishing a technical multisector platform, developing a national policy for food security and nutrition, and launching the Central African parliamentary network against malnutrition.

SUN country actors are making use of valuable networks to inform country-level work. In 2017, the SUN movement and the Emergency Nutrition Network brought together representatives from a number of partner organizations and United Nations agencies in the movement's first workshop on knowledge management. This gathering set an agreed working definition of 'knowledge management' for the movement and garnered agreement around processes for coordinating knowledge management efforts in support of SUN country priorities.

UNICEF helped sustain and revitalize the national SUN movement in Haiti, where it supported a SUN self-evaluation, which had not been conducted for two consecutive years. This stock-taking exercise helped identify gaps, strengths and weaknesses in the implementation of the SUN road map in Haiti and paved the way to develop a SUN action plan including policies and strategies, governance, budget and a results framework.

Nutrition monitoring for performance

UNICEF helps countries improve routine health and nutrition information systems by providing technical guidance and building capacity among partners to collect and use programme data for decision-making. Increasingly, countries are collecting disaggregated nutrition data through national information systems, which is critical to evaluating whether key interventions are achieving equity. Ninety-seven countries reported having national information management systems that disaggregate data on nutrition in 2017, falling just short of the target of 100 countries (P4.e.1).

With UNICEF support, many national governments have increased the number of nutrition indicators monitored through surveys and routine systems. In China, UNICEF helped standardize questionnaires for the country's Sixth National Health Services Survey, which will make internationally comparative nutrition data available for China for the first time. In Ethiopia, with UNICEF advocacy and technical support, the number of nutrition indicators included in the health management information system increased from 3 to 10. With UNICEF support, the

SPOTLIGHT ON INNOVATIONS – REAL-TIME MONITORING TO IMPROVE SERVICE COVERAGE AND QUALITY

A real-time monitoring platform on nutrition service delivery was institutionalized throughout **Bangladesh**, with support from UNICEF. Using a mobile application on tablets and smartphones, district nutrition support officers and front-line supervisors input observations on the quality of nutrition services at health facilities, which are linked to an online dashboard. The real-time data visualization and analysis helps strengthen routine monitoring and enables timely responses. This system was implemented in 500 facilities in 43 districts in 2017 and will be expanded to all 64 districts in 2018.

In **Sierra Leone**, UNICEF worked with the Ministry of Health to set up a communication and monitoring system at community level to collect data and send preventative information to communities using RapidPro after the landslide in 2017. To do this, 300 community workers were trained on prevention messaging, identifying cholera cases and screening children for malnutrition. Nutrition indicators tracked included the number of children screened, MUAC data on malnutrition, sightings of infant formula donations, and the transfer of children to outpatient therapeutic programmes. Over two weeks of response activity, more than 13,640 children were screened for malnutrition in the seven affected areas alone, a total of 468 cases of MAM and SAM were reported, and 7 health centres received RUTF.

In **Yemen**, a new mobile-based nutrition reporting system was launched in Hajjah, Hodeidah, Sa'ada and Taiz governorates in 2017. Using an Android application on their own smartphones, district health offices are now reporting weekly on the numbers of children screened, nutrition supply stocks, and the status of outpatient therapeutic programmes. The programme will expand to Abyan, Lahj and Shabwah in early 2018.

Girls smile and play together in Indonesia.

Government of Ethiopia developed the Unified Nutrition Information System for Ethiopia, combining nutrition-sensitive and nutrition-specific indicators. The system includes indicators from 10 of 13 sectors and will soon be integrated within the District Health Information System, a platform that allows governments to collect, manage and analyse health and nutrition data.

Many countries are improving technology and leveraging innovations to improve programme monitoring, including Bangladesh, Sierra Leone and Yemen (*see 'Spotlight on innovations – Real-time monitoring to improve service coverage and quality'*). To facilitate access to nutrition information in India, UNICEF developed www.NutritionINDIA.info, an online dashboard that consolidates nutrition data on children, women and adolescents from multiple sources. The data are disaggregated by sex, caste and wealth quintile for all states and can be tracked back to district level in 15 UNICEF programme states. A health management information system-based dashboard was also developed for the Anaemia Free India programme for 33 states and Union Territories and serves as a model for tracking programme performance data.

Capacity-building of health and nutrition staff is critical to improve data quality and availability. To support this process in Afghanistan, UNICEF and WHO provided technical assistance to the government to implement the National Nutrition Surveillance System in 175 health facilities and 868 community sentinel sites across Afghanistan's 34 provinces. Training on the system was provided to more than 1,700 community health workers, supervisors and officers. As a result of the training, the number of community surveillance sentinel sites conducting reporting increased from 564 (65 per cent) in the first quarter of 2017 to 645 (74 per cent) in the third quarter (out of a total of 868 sites).

As part of the health system strengthening work in Somalia, UNICEF developed guidelines and implemented capacity strengthening activities for managers of the Somali national Health Data Management Systems. The system disaggregates data by gender, and its roll-out has ensured greater access to information at regional and central levels, which will increasingly be utilized to inform the health sector strengthening agenda.

UNICEF's global NutriDash platform is a tool for supporting programme performance monitoring. In 2017, NutriDash collected nutrition programme data from 110 countries, and facilitated forecasting of key nutrition supplies such as RUTF, vitamin A capsules and MNPs. Five training webinars were organized with country offices to improve the timeliness and quality of NutriDash data submissions.

Generating evidence and knowledge for better programming

UNICEF continued to be a global knowledge leader in maternal and child nutrition in 2017, generating research and evidence and documenting best practices (*see Case Study 7*). UNICEF's contribution to the global knowledge base for nutrition is well reflected by its publications in peer-reviewed journals. Globally, UNICEF staff authored or

co-authored 75 peer-reviewed articles on maternal and child nutrition in 2017, exceeding the target of 50 publications per year (P4.f.1).

In 2017, UNICEF made efforts to strengthen knowledge generation, making it the foundation of its policies, programmes and advocacy for nutrition. UNICEF published 41 issues of *Nutrition Weekly*, a new knowledge management product intended to share advocacy, research, policy and programme evidence on maternal and child nutrition with UNICEF nutrition staff around the world. UNICEF also disseminated six publications showcasing its work through *UNICEF – Working to Improve Nutrition at Scale (UNICEF WINS)*, which has a much broader audience, including donors and partners.

Within countries, UNICEF continued to conduct research and generate evidence to support national priorities. In India, *Nutrition Reports* is a UNICEF working paper series that generates evidence on nutrition subjects requiring debate and policy action; over the years, these reports have helped build consensus for government plans and policies. In China, UNICEF gathered evidence to drive advocacy and inform capacity development efforts, including by conducting studies on the cost of not breastfeeding, the relationship between breastfeeding and essential newborn care, and the long-term effects of nutrient supplementation on adolescent development.

UNICEF undertook a number of studies in Kenya to inform its advocacy on investing in multisectoral approaches to

CASE STUDY 7: INDONESIA: KNOWLEDGE GENERATION TO IMPROVE THE NUTRITION STATUS OF ADOLESCENT GIRLS AND BOYS

In Indonesia, a multisectoral model package of essential nutrition, education, child protection, and health interventions for adolescents is being designed in partnership with the Ministry of Health and other line ministries. This is being done through evidence-based advocacy efforts to strengthen government ownership, and to mainstream adolescent nutrition into relevant health sector budgets, plans and strategies.

To increase the evidence base for the design of high-quality adolescent nutrition programmes, UNICEF carried out three evidence-generation activities on adolescent nutrition in Indonesia – a qualitative inquiry on the dietary and physical activity behaviours of adolescents, a baseline survey assessing the nutritional status of adolescent girls and boys and its determinants, and a landscape review to examine policies and guidelines addressing adolescent nutrition.

The qualitative research explored behaviour related to eating and physical activity among adolescent girls and boys, and gathered the perspectives of adolescents, their families and communities on the factors influencing this behaviour. The baseline survey provided a comprehensive analysis of the demographic, socio-economic, and nutrition and health status of adolescents, while also investigating the household, parental and individual risk factors affecting adolescent nutrition. The evidence indicates that adolescent undernutrition is ubiquitous in Indonesia, while levels of overweight and obesity affect an increasing number of adolescents. The research examined the gender dimensions of eating behaviour and physical activity of adolescent girls and boys, finding that adolescents are physically inactive, and adolescent girls' physical activity is particularly limited because of gender norms. Adolescents frequently eat outside of the home and girls prefer to eat with their friends. In addition, schools are an important source of food for adolescents.

UNICEF also reviewed existing legislation, policies, strategies, plans, programmes and technical guidelines related to adolescent nutrition. The review found that adolescent nutrition is not yet considered a priority in the national development agenda, and few nutrition-specific policies and programmes have been designed to improve adolescent nutrition. A series of national and subnational consultations on adolescent nutrition were conducted in Jakarta, Klaten and Lombok Barat to gather multisectoral insights on the essential nutrition intervention package, and the most effective delivery mechanism to reach the most vulnerable groups of adolescents.

Using the evidence generated through the studies and consultations, UNICEF designed a model package of interventions to improve nutrition services for adolescents, enhance their access to information, and stimulate policy dialogue with key decision-makers to proactively address the needs of adolescents in society. In 2018, the designed intervention package will be tested in selected districts in collaboration with local government authorities and other partners. These interventions will also be aligned, integrated and combined with other interventions and services aimed at improving adolescent health and well-being, as well as those addressing harmful cultural and gender norms.

stunting reduction. These studies included: (1) using cash and health education to deliver nutrition counselling to women enrolled in the cash transfer programme (findings due in 2018); (2) researching nutrition messaging in community-led total sanitation initiatives, which revealed a positive impact of knowledge on some sanitation practices and improved breastfeeding knowledge at the community level; and (3) a cost-of-diet study in Turkana, which demonstrated that the current cash transfer value met only 10 per cent of food requirements and needed to be increased during the drought.

CHALLENGES, REFLECTIONS AND FUTURE DIRECTION

National governments have continued to look to UNICEF for support and guidance in developing multisectoral policies, strategies and programmes. As the world unites in striving towards the SDGs, UNICEF's multisectoral programming will help to drive progress in reducing stunting.

UNICEF values the support of resource partners with a willingness to invest in multisectoral approaches, such as the Government of the Netherlands, which has supported the scale-up of such interventions in sub-Saharan Africa, and has generously committed to support UNICEF with flexible, thematic funds for the 2018–2021 period. These flexible resources will provide critical support to long-term planning, systems strengthening and improving cross-sectoral convergence for greater impact, while adding the voice of our thematic funds partners to UNICEF's global voice for children's right to food and nutrition as a human right.

UNICEF has helped governments make important strides in strengthening nutrition monitoring. However, work remains to be done to strengthen routine information systems and improve data collection to inform programme decision-making; faster progress in this area will be needed to achieve national and global nutrition targets.

In the past, evidence generation and knowledge management have not always been prioritized or undertaken strategically; but this changed in 2017 with the development of a new knowledge-generation strategy and the dissemination of key knowledge products. These tools have helped set the stage for the transition into the new strategic plan period and will provide the foundation for UNICEF advocacy and programmes in the future.

Karine feeds her nine-month-old daughter Denisse, who was born with congenital Zika syndrome, at the family's home in Guatemala City, Guatemala.

Cross-cutting programme areas

A number of cross-cutting programme areas support the work of the nutrition programme. This section highlights cross-cutting strategies and programmes related to three areas: human rights, disability and C4D. Other cross-cutting programme areas, such as gender, ECD, and adolescent development and participation, are integrated within the programme area sections of this report, reflecting the holistic and integrated nature of nutrition programming. The sections that follow provide an overview of UNICEF's global approaches to these cross-cutting issues, followed by country-level examples.

NUTRITION AND HUMAN RIGHTS

Good nutrition is foundational to realizing all the rights of the child, especially the most vulnerable. UNICEF has continued to take a human rights-based approach to its nutrition programming by supporting governments in fulfilling their obligations to protect, respect and fulfil the health and nutrition rights of all children, as stipulated in the Convention on the Rights of the Child.

The protection, promotion and support of breastfeeding, for example, is a right anchored in Article 24(e) of the Convention on the Rights of the Child, which calls on governments to ensure that all segments of society are informed and have access to education and support with regard to nutrition in general and the benefits of breastfeeding in particular. In discussions over the years with the Committee on the Rights of the Child in Geneva, UNICEF, WHO and the International Baby Food Action Network (IBFAN) have successfully argued that the International Code of Marketing of Breast-milk Substitutes, adopted by the World Health Assembly in 1981, is an "appropriate measure" that States parties to the Convention on the Rights of the Child are legally obliged to implement through national regulations. UNICEF guides countries in these efforts by providing support to adopt national Code legislation, implement maternity leave policies, and make health facilities and communities more breastfeeding-friendly.

Emerging work on tackling the growing epidemic of child overweight and obesity also calls for a human rights-based approach. UNICEF produced a report entitled 'Food Marketing and Children's Rights: A legal analysis',[63] which is based on the notion that the Convention on the Rights of the Child requires governments to protect children from the negative impacts of marketing unhealthy food. This interpretation is based on the new WHO evidence-based recommendations on the marketing of foods and non-alcoholic beverages to children. For businesses, the Convention on the Rights of the Child provides direction for respecting and supporting children's rights in their policies and practices, and thus provides the foundation for a child rights-based approach to ending childhood obesity and the prevention of non-communicable diseases.

NUTRITION FOR CHILDREN AND ADOLESCENTS WITH DISABILITIES

Historically, nutrition programming has focused almost exclusively on protecting children from disability throughout the life cycle. For example, iron and folic acid supplementation prevents birth defects, and vitamin A supplementation protects children from loss of sight due to vitamin A deficiency. Yet the link between nutrition and disability goes much deeper than this. Well-nourished children of all abilities are better placed to participate in and contribute to their communities – and to achieve this, nutrition services and programmes must be accessible to all children, including those with disabilities or those whose caregivers have disabilities.

Children with disabilities may require special feeding methods, adapted food, additional time to eat or specific nutritional requirements that are tailored to meet their individual needs. In the past, UNICEF has contributed to guidance on these issues, for example, in the context of Zika outbreaks. As part of the updating of the Infant and Young Child Feeding in Emergencies Operational Guidance for Emergency Relief Staff and Programme Managers in 2017, UNICEF provided revisions to ensure that the guidance was inclusive of children and caregivers with disabilities in all emergency relief operations. This includes, for example, ensuring that field staff have a good understanding of local perceptions of child disability and associated feeding and care practices, and are aware of the nutrition guidance on including children and adolescents with disabilities in humanitarian action.[64]

COMMUNICATION FOR DEVELOPMENT AND NUTRITION

C4D strategies help UNICEF understand the impact of beliefs, values and norms on the feeding practices of children and their families, translating this information into interactive communications with children and their caregivers. In 2017, UNICEF worked to gather evidence on the effectiveness of C4D strategies in supporting breastfeeding among working mothers. Based on these findings, UNICEF developed C4D strategies for promoting breastfeeding in the workplace in Bangladesh and Kenya. The strategies were aligned with existing national policies and included monitoring and evaluation plans, with indicators to monitor the impact of the C4D interventions on the awareness and support of different target groups, as well as mothers' intentions, self-efficacy and practices.

To better understand social norms affecting breastfeeding in Ghana, UNICEF undertook a study on behaviours related to child health and nutrition, feeding practices and hygiene. On the basis of the results, a C4D strategy was developed to support the Mother and Baby-Friendly Health Facility Initiative in Upper East Region, including interventions in health facilities and communities, by government entities and NGO partners.

C4D strategies have also been effective in improving eating habits to address overweight and obesity. In Mexico, for example, such strategies were used to improve health and nutrition habits among 140,000 families in urban settings, with 69 per cent of the participating families in Mexico City and Guadalajara confirming that the C4D materials produced by UNICEF Mexico impacted their nutritional choices.

CASE STUDY 8: CAMEROON: C4D STRATEGIES TO IMPROVE BREASTFEEDING PRACTICES

In Cameroon, C4D strategies are helping to address cultural norms and practices that pose barriers to breastfeeding. Studies have shown that breastfeeding mothers, particularly in northern Cameroon and among the Masa people, consider colostrum to be 'bad milk'. Therefore, when a breastfeeding woman becomes pregnant again, it is considered imperative to wean the breastfeeding child immediately. In addition, breastmilk is often perceived as insufficiently nutritious, resulting in the early introduction of other fluids or foods. When children fail to thrive, community members often rely on traditional healers as a first course of action, who may not be able to provide appropriate nutritional advice.

Mothers of malnourished children often experience stigmatization and discrimination due to the perception that they are at fault. The mothers develop a sense of shame that becomes a barrier to accessing health care. Consequently, many children with acute malnutrition died without access to therapeutic care. Those who were referred to the nearest health facilities had serious medical complications, making their treatment difficult.

In response to these persistent challenges, UNICEF developed a C4D strategy focused on reducing discrimination against the mothers of malnourished children and reducing the social barriers to caring for them. Community mobilization campaigns began in 2012/13 and have now been generalized across the four regions supported by UNICEF (Far North, North, Adamawa and East). The strategy focuses on empowering communities and families and increasing their knowledge on and skills in the best child feeding and care practices. To do this, UNICEF engages leaders, builds the capacities of community health workers and mothers, and partners with NGOs for implementation and monitoring activities.

Men in the community have also been engaged in the programme through the establishment of management committees comprised of men, women and elders, which contribute to the management of crisis situations (rumours, reticence, refusal) and encourage caregivers and malnourished children to go to the health centre. The strategy has also engaged traditional birth attendants, which has helped shift beliefs and ensure malnutrition is identified as a real health problem.

UNICEF has been working in partnership with the government, which has recently endorsed this approach as a complementary strategy for scaling up malnutrition screening at community level. Several international NGOs are also implementing the approach in other districts.

FUTURE WORKPLAN: UNICEF STRATEGIC PLAN, 2018–2021

In reflecting on the achievements and challenges of the past four years, UNICEF has the opportunity to realign its vision and chart a new way forward towards a world without malnutrition. What will remain the same, however, is a commitment to programmes that are rights-driven, results-based, systems-focused and scalable.

Over the past four years, UNICEF has made substantial progress towards Outcome 4, improved and equitable use of nutrition support and improved nutrition and care practices. Driven by the scale-up of IYCF counselling and support, a number of countries have seen increases in exclusive breastfeeding. Others have improved the coverage of key micronutrient interventions such as VAS and household consumption of iodized salt. With the scale-up of SAM management, many countries are improving treatment coverage and quality, and addressing bottlenecks, in both humanitarian and development contexts. Despite the immense challenges presented by the multitude of large-scale humanitarian crises in 2017, UNICEF continued to lead and coordinate rapid and effective nutrition responses in places of greatest need.

At the close of its Strategic Plan, 2014–2017, UNICEF has identified a number of lessons learned that will shape planning and programmes in the next strategic plan. First, there is a need to move away from an intervention-based approach towards putting children, adolescents and women at the centre of programming, looking at what each child needs to guarantee good nutrition at different points across the life cycle. Second, UNICEF will focus on putting food and diets at the heart of its advocacy and programming, ensuring food security when it matters most – during early childhood.

Third, the experiences of the past four years reaffirm the need for UNICEF to be responsive to the changing realities of nutrition, and support programming at scale for school-age children and adolescents, including through links with the education system. Overweight and obesity are increasingly affecting the poor, and UNICEF must support policies and programmes that address the triple burden of malnutrition at scale: stunting and wasting, deficiencies in vitamins and other micronutrients, and overweight and obesity. Last, there are important opportunities to strengthen knowledge, data and evidence generation, which will be critical for supporting UNICEF's advocacy, programming and resource-mobilization.

Two-year-old Maria John smiles after eating her hourly ration of ready-to-use therapeutic food at her family's home in Juba, South Sudan. Maria recovered from severe acute malnutrition through a UNICEF-supported programme.

Drawing from the experience in 2017, UNICEF will also work towards a stronger focus on areas where progress has been slow, such as on improving diets, improving women's nutrition and scaling up care for children with SAM in all contexts. And new commitments are being made to respond to areas of emerging importance, such as the nutrition of school-age children, the nutrition of adolescents, and the prevention of overweight and obesity. In the context of the 2030 Agenda and with the launch of the UNICEF Strategic Plan, 2018–2021, there are tremendous opportunities to improve multisectoral programming and accelerate progress in areas where efforts have fallen short in the past, such as closing the gap between the global burden of SAM and the number of children being reached with treatment and care.

With the increasingly protracted nature of humanitarian crises, greater coherency between humanitarian and development programming will be critical to managing risks and vulnerabilities and preparing communities to withstand and bounce back from shocks, stresses and crises. Flexible funding streams will allow for greater investments in systems strengthening, leading to strengthened resilience even in the most fragile contexts.

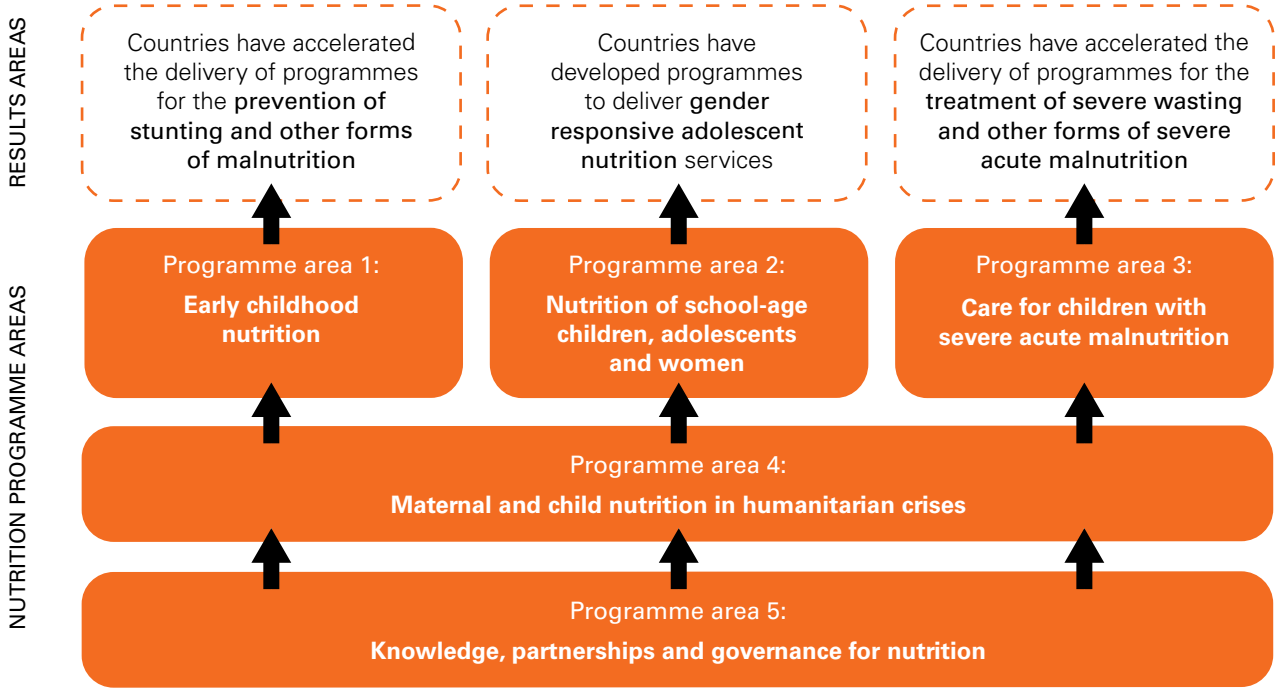
UNICEF's nutrition work will fall under Goal 1 of the new strategic plan – every child survives and thrives – with three overarching results areas led by UNICEF's Nutrition Programme: (1) children receive services for the prevention of stunting and other forms of malnutrition; (2) children receive services for the treatment of severe wasting and other forms of severe acute malnutrition; and (3) adolescent girls and boys receive gender-responsive health and nutrition services for the prevention of anaemia and other forms of malnutrition.

In order to deliver in the new strategic plan, UNICEF's work in nutrition will be organized according to five programme areas: early childhood nutrition; nutrition of school-age children, adolescents and women; care for children with severe acute malnutrition; maternal and child nutrition in humanitarian crises; and knowledge, partnerships and governance for nutrition (*Figure 11*).

To drive progress towards the new strategic plan objectives, UNICEF will lead with the commitments outlined together with country, regional and headquarters offices in its Global Compact to Reduce Stunting, targeting resources and efforts to reduce stunting and wasting in the places where opportunities and needs are greatest.

As the world commits its resources and efforts towards the SDGs, UNICEF's vast country presence, multisectoral experience and equity-driven approach make it well placed to lead progress towards a more sustainable, prosperous and well-nourished world.

FIGURE 11: Nutrition-related results in Goal Area 1 and related programme areas



Children wait for lunch at a kindergarten in Nalaikh district, Ulaanbaatar, Mongolia.

EXPRESSION OF THANKS

UNICEF wishes to acknowledge the support of all government resource partners and National Committees for their generous contributions to achieve results in nutrition in 2017. UNICEF would like to extend a special note of thanks to the Government of the Netherlands and the Government of Luxembourg; and the National Committees of Poland and the Republic of Korea for their thematic contributions. UNICEF also gratefully acknowledges the thematic partnership agreement with the Government of the Netherlands for the 2018–2021 strategic plan period.

UNICEF will continue exploring new ways of enhancing visibility for partners who provide global level thematic funding and looks forward to brainstorming with partners themselves on how to make such an approach fit for purpose.

ABBREVIATIONS AND ACRONYMS

BFHI	Baby-friendly Hospital Initiative (UNICEF–WHO)
C4D	Communication for Development
CCCs	Core Commitments for Children (in humanitarian action)
CORTASAM	Council on Research and Technical Advice on Severe Acute Malnutrition
DFID	United Kingdom Department for International Development
ECD	early childhood development
FAO	Food and Agricultural Organization of the United Nations
GAIN	Global Alliance for Improved Nutrition
GNC	Global Nutrition Cluster
IBFAN	International Baby Food Action Network
ILO	International Labour Organization
IPC	Integrated Phase Classification
IYCF	infant and young child feeding
LGA	local government area
MAM	moderate acute malnutrition
MMS	multiple micronutrient supplementation
MNP	Multiple micronutrient powder
MUAC	mid-upper-arm circumference
NetCode	Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes and Subsequent relevant World Health Assembly Resolutions
NGO	non-governmental organization
NI	Nutrition International
NID	National Immunization Day (for polio)
NMIS	Nutrition Management Information System
PPTCT	prevention of parent-to-child transmission
RRM	rapid response mechanism
RUTF	ready-to-use therapeutic foods
SAM	severe acute malnutrition
SDG	Sustainable Development Goal
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SMS	Short Message Service
SPRING	Strengthening Partnerships, Results and Innovations in Nutrition
SUN	Scaling Up Nutrition movement
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
USAID	United States Agency for International Development
VAS	vitamin A supplementation
WASH	water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WIFS	weekly iron and folic acid supplementation

ENDNOTES

1. Social media mentions were highest in the United States, Spain, Nigeria, India, Venezuela, the United Kingdom, Argentina, Mexico and Uganda.

2. The global prevalence of stunting in children under 5 is 22.9 per cent

3. United Nations Children's Fund, World Health Organization and World Bank Group, 'Joint Malnutrition Estimates – 2017 edition', UNICEF, WHO and World Bank, 2017, <https://data.unicef.org/resources/joint-child-malnutrition-estimates-2017-edition/>, accessed 22 April 2018.

4. Development Initiatives, *Global Nutrition Report 2017: Nourishing the SDGs*, Development Initiatives, Bristol, UK, 2017, <www.globalnutritionreport.org/the-report/>, accessed 3 April 2018.

5. United Nations Children's Fund, *Progress for Every Child in the SDG Era*, UNICEF, New York, 2018, <https://data.unicef.org/wp-content/uploads/2018/03/Progress_for_Every_Child_V4.pdf>, accessed 22 April 2018.

6. Copenhagen Consensus 2012, 'Expert Panel Findings', Copenhagen Consensus Center, 2012, <www.copenhagenconsensus.com/sites/default/files/outcome_document_updated_1105.pdf>, accessed 3 April 2018.

7. United Nations Children's Fund, *Narrowing the Gaps: The power of investing in the poorest children*, UNICEF, New York, 2017, <www.unicef.org/publications/index_96534.html>, accessed 3 April 2018.

8. The Nutrition for Growth (N4G) Stakeholders Group, led by the Department for International Development (DFID), aims to provide coordinated leadership across the international community to secure commitments to address malnutrition. Members include DFID, the US State Department, representatives of the governments of Brazil and Japan, the Bill & Melinda Gates Foundation, Children's Investment Fund Foundation, WHO, FAO, the SUN Movement and the Global Nutrition Report.

9. World Health Organization, 'Global Targets – To improve maternal, infant and young child nutrition', WHO, <www.who.int/nutrition/global-target-2025/en/>, accessed 18 April, 2018.

10. See: Nutrition for Growth, 'Nutrition for Growth', Nutrition for Growth, 2017, <https://nutritionforgrowth.org/wp-content/uploads/2016/06/N4G-insert-4-19-17-final1.pdf>, accessed 3 April 2018.

11. United Nations Children's Fund, 'Revised Supplementary Programme Note on the Theory of Change for the UNICEF Strategic Plan, 2014-2017', E/ICEF/2014/CRP.14, UNICEF, 6 May 2014, <www.unicef.org/strategicplan/files/2014-CRP_14-Theory_of_Change-7May14-EN.pdf>, accessed 3 April 2018.

12. The two nutrition impact-level indicators in the UNICEF Strategic Plan, 2014–2017.

13. United Nations Children's Fund, 'Revised Supplementary Programme Note on the Theory of Change'.

14. Twenty-seven countries at baseline, towards a target of 40 countries in 2017.

15. Fifty at baseline, towards a target of 70 by 2017.

16. The 12 global nutrition initiatives in which UNICEF was chair, coordinating committee member or board member in 2017 were: Food Fortification Initiative; Global Alliance for Vitamin A; Global Breastfeeding Collective; Global Nutrition Cluster; Home Fortification Technical Advisory Group; Infant and Young Child Feeding in Emergencies Core Group; Iodine Global Network; Micronutrient Forum; Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes; No Wasted Lives; Scaling Up Nutrition Movement; and UN Network for SUN.

17. World Health Organization, United Nations Children's Fund, *Global Strategy for Infant and Young Child Feeding*, WHO, Geneva, 2003, <www.who.int/nutrition/publications/infantfeeding/9241562218/en/index.html>, accessed 9 April 2018.

18. The minimum dietary diversity refers to the percentage of children aged 6–23 months who were fed at least four out of seven food groups the previous day. The seven food groups are: (1) grains, roots and tubers; (2) vitamin A-rich fruits and vegetables; (3) flesh foods, such as meat, fish and poultry; (4) legumes, nuts and seeds; (5) eggs; (6) other fruits and vegetables; and (7) dairy products.

19. United Nations Children's Fund, *From the First Hour of Life: Making the case for improved infant and young child feeding everywhere*, UNICEF, New York, 2016.

20. Minimum dietary diversity estimates are based on the old indicator definition, as described in endnote 18.

21. Armenia, Belize, Burundi, the Congo, the Democratic Republic of the Congo, El Salvador, Guinea-Bissau, Lesotho, Mali, Mauritania, Mexico, Myanmar, Samoa, Sao Tome and Principe, the Sudan, Swaziland, Thailand, the United Republic of Tanzania, Zambia and Zimbabwe.

22. The minimum acceptable diet is a composite indicator for feeding practices among children 6–23 months of age. It refers to the percentage of children who were fed the minimum dietary diversity (see endnote 16) and the minimum meal frequency (i.e., at least two meals per day for breastfed children 6–8 months old and three meals per day for breastfed children 9–23 months old. Non-breastfed children require at least four meals a day between 6 and 23 months of age).

23. Available online at: United Nations Children's Fund, 'Community Based Infant and Young Child Feeding', UNICEF, 14 November 2017, <www.unicef.org/nutrition/index_58362.html>, accessed 3 April 2018.

24. Care for Child Development is a holistic early childhood development intervention providing recommendations for cognitive stimulation and social support to young children, through sensitive and responsive caregiver-child interactions. See: United Nations Children's Fund, 'Care for Child Development Package', UNICEF, 2012, <www.unicef.org/earlychildhood/index_68195.html>, accessed 3 April 2018.

25. See: Quality of Care Network, homepage, www.qualityofcarenetwork.org/, accessed 3 April 2018.

26. The evaluation was based on the Household Dietary Diversity Score, which categorizes food into 12 groups. The score was applied individually to evaluate diet diversity for children 6–59 months of age, categorizing food into nine groups.

27. World Health Organization, United Nations Children's Fund, *Guideline – Updates on HIV and Infant Feeding*, WHO, Geneva, 2016, <www.who.int/maternal_child_adolescent/documents/hiv-infant-feeding-2016/en/>, accessed 18 April, 2018.

28. See: Global Breastfeeding Collective, *Nurturing the Health and Wealth of Nations – The investment case for breastfeeding,* United Nations Children's Fund, New York, and World Health Organization, Geneva, July 2017, <www.who.int/nutrition/publications/infantfeeding/global-bf-collective-investmentcase/en/>, accessed 3 April 2018.

29. See: United Nations Children's Fund, 'A Global Breastfeeding Call to Action', UNICEF, 31 July 2017, <www.unicef.org/nutrition/index_98477.html>, accessed 3 April 2018.

30. See: United Nations Children's Fund, '#breastfeeding', UNICEF, n.d., <www.unicef.org/breastfeeding/>, accessed 3 April 2018.

31. See: World Health Organization, 'International Code of Marketing of Breast-milk Substitutes', WHO, Geneva, 1981, <www.who.int/nutrition/publications/code_english.pdf>, accessed 3 April 2018.

32. World Health Organization, 'NetCode Toolkit for Ongoing Monitoring and Periodic Assessment of the Code', WHO, 2017, <www.who.int/nutrition/netcode/toolkit/en/>, accessed 3 April 2018.

33. United Nations Children's Fund, NutriDash: Facts and Figures. *Nutrition Programme Data for the SDGs* (2015–2030), UNICEF, New York, 2017.

34. Point-of-use fortification was previously referred to as 'home fortification'. WHO has started to use the term 'point-of-use fortification', as micronutrient powders can be added to energy-containing foods at home or in any other place where meals are consumed, such as schools, nurseries and refugee camps.

35. The package of interventions included VAS, deworming, SAM screening and outpatient treatment, and support for IYCF for children aged 6–59 months.

36. United Nations Children's Fund, F*rom the First Hour of Life*, UNICEF, New York, 2016.

37. Minimum diet diversity is an indicator of dietary quality. It refers to the percentage of children aged 6–23 months who were fed foods from at least four (out of seven) food groups during the previous day.

38. United Nations Children's Fund, NutriDash: Facts and Figures, UNICEF, New York, 2017.

39. Siekmans, K., et al., 'The potential role of micronutrient powders to improve complementary feeding practices', *Maternal & Child Nutrition*, vol. 13, no. S2, 15 October 2017, art. e12464, <http://onlinelibrary.wiley.com/doi/10.1111/mcn.12464/full>, accessed 3 April 2018.

40. See: Moran, Victoria Hall, and Rafael Pérez-Escamilla, eds., 'Micronutrient Powders Consultation: Lessons learned for operational guidance', *Maternal & Child Nutrition*, vol. 13, no. S1, September 2017, <http://onlinelibrary.wiley.com/doi/10.1111/mcn.2017.13.issue-S1/issuetoc>, accessed 3 April 2018.

41. The supplement includes five or six papers, published separately as they became available. See: <http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1740-8709/earlyview>, accessed 12 April 2018.

42. World Health Organization, *WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience*, WHO, Geneva, 2016.

43. Task Force on Multiple Micronutrient Supplementation in Pregnancy in Low Income Countries. See: The New York Academy of Sciences, 'Task Force on Multiple Micronutrient Supplementation in Pregnancy in Low Income Countries', 15 November 2015, <www.nyas.org/programs/the-sackler-institute-for-nutrition-science/task-force-on-multiple-micronutrient-supplementation-in-pregnancy-in-low-income-countries/>, accessed 3 April 2018.

44. United Nations Children's Fund, 'Iodine Deficiency', UNICEF, n.d., <https://data.unicef.org/topic/nutrition/iodine-deficiency/>, accessed 3 April 2018.

45. United Nations Children's Fund, 'Iodine Deficiency', UNICEF, n.d., <https://data.unicef.org/topic/nutrition/iodine-deficiency/>, accessed 3 April 2018.

46. UNICEF Global database, 2018, based on Multiple Indicator Cluster Surveys (MICS), Demographic and Household Surveys (DHS) and other nationally representative household surveys, 2011–2018.

47. Pretell, Eduardo A., et al., 'Elimination of Iodine Deficiency Disorders from the Americas – A public health triumph', *Lancet Diabetes Endocrinology*, vol. 5, no. 6, June 2017, pp. 412–414.

48. Refers to 82 UNICEF programme countries. Globally, however, there are 87 countries with legislation to mandate fortification of at least one industrially milled cereal grain.

49. Closser, S., et al., 'The Impact of Polio Eradication on Routine Immunization and Primary Health Care: A mixed-methods study', *The Journal of Infectious Diseases*, vol. 210, suppl. 1, 1 November 2014, pp. S504–S513.

50. Mounier-Jack, S., et al., 'One Year of Campaigns in Cameroon: Effects on routine health services', *Health Policy and Planning*, vol. 31, no. 9, 11 May 2016, pp. 1225–1231.

51. Wirth, J.P., et al., 'Vitamin A Supplementation Programs and Country-Level Evidence of Vitamin A Deficiency', *Nutrients*, vol. 9, no. 3, 2017, p. E190.

52. United Nations Children's Fund, *NutriDash: Facts and Figures*, UNICEF, New York, 2017.

53. UNICEF East and Central Africa, 'Accelerating Effective and Sustainable Management of SAM – Focusing on strengthened integration of the management of SAM within the health system', Deep Dive Workshop Report, June 2017.

54. UNICEF Afrique de l'Ouest et Centrale, 'Prise en charge de la malnutrition aiguë sévère. Accélérer la prise en charge efficace et durable de la MAS. L'intégration de la prise en charge de la MAS dans le système de santé', Consultation approfondie rapport de l'atelier, June 2017.

55. Dent, N., and S. Bruneau, 'Increasing the Scale Up and Coverage of Severe Acute Malnutrition: Africa Regional Trends and Country Scoping: 2012–2017', Working Document, May 2017; Dent, N., and S. Bruneau, 'Renforcer la mise à l'échelle et la couverture de la malnutrition aiguë sévère : Tendances régionales en Afrique et étude de cadrage : 2012-2017', Document de travail élaboré de l'UNICEF pour les réunions approfondies sur la MAS, May 2017.

56. 'Exceptional circumstances' in the interim guidance refer to acute crisis situations that lack either outpatient therapeutic programmes, target supplementary feeding programmes or both.

57. Current guidance defines the burden of SAM as the sum of the existing (prevalent) cases and the new (incident) cases, but in the absence of incidence data, practical calculation of the SAM burden often relies on prevalence of SAM and an 'incidence correction factor'. This new work aims to build the evidence base for incidence of SAM in different countries and contexts to improve estimation of the SAM burden and programme planning.

58. United Nations Children's Fund, *Committed to Nutrition: A toolkit for action*, UNICEF, June 2017, <http://nutritioncluster.net/wp-content/uploads/sites/4/2017/11/Committed-to-Nutrition.-A-TOOLKIT-FOR-ACTION.pdf>, accessed 18 April 2018.

59. Sphere Project, 'Minimum Standards in Food Security and Nutrition', ch. 3 in *The Sphere Handbook*, Sphere, <www.spherehandbook.org/en/how-to-use-this-chapter-3/>, accessed 18 April 2017.

60. Infant Feeding in Emergencies Core Group, *Infant and Young Child Feeding in Emergencies: Operational guidance for emergency relief staff and programme managers*, version 3.0., IFE Core Group, New York, October 2017, <www.ennonline.net/attachments/2671/Ops-G_2017_WEB.pdf>, accessed 18 April 2018.

61. A more detailed description of minimum standards for SAM treatment, including performance indicators, can be found in: Sphere Project, *The Sphere Handbook*.

62. A summary, briefing note and discussion paper are available online. See: <www.ennonline.net/ourwork/reviews/stuntinginprotractedemergencies>, accessed 18 April, 2018.

63. United Nations Children's Fund, *Food Marketing and Children's Rights: A legal analysis*, UNICEF, New York, February 2018.

64. See: United Nations Children's Fund, *Including Children with Disabilities in Humanitarian Action: Nutrition guidance*, <http://training.unicef.org/disability/emergencies/nutrition.html>, accessed 18 April 2018.

65. United Nations Children's Fund, *Narrowing the Gaps: The power of investing in the poorest children*, UNICEF, New York, 2017.

ANNEX 1: DATA COMPANION

Visualizing achievements

Each achievement is expressed as a percentage and visualized through colour coding:

Green

Output level
Average achievement of indicators for the output is at or above 100%

Amber

Output level
Average achievement of indicators for the output is between 60% and 99%

Red

Output level
Average achievement of indicators for the output is less than 60%

Impact Indicator	Baseline*	2017 Target	2017 Update **
4a. Number of children under 5 years who are moderately and severely stunted	170 million (2010)	approx. 100 million (2025)	155 million (2016)
4b. Percentage of women of reproductive age with anaemia	38% pregnant, 29% non- pregnant (1995–2011)	50% reduction of anaemia in women of reproductive age	40.1% pregnant, 32.5% non-pregnant (2016)

Outcome Indicator	Baseline*	2017 Target	2017 Update**
P4.1 Countries with a current exclusive breastfeeding rate among children 0–5 months old ≥50% and no recent significant decline	27 (2007–2013)	40	35 out of 109 UNICEF programme countries with data (2010–2017)
P4.2 Countries with at least 90% of households consuming iodized salt	24 (2007–2013)	25	27 out of 79 UNICEF programme countries with data (2010–2017)
P4.3 Countries with at least 80% of primary caregivers engaged in early childhood stimulation for children aged 3–5 years (36–59 months) at home	16 (2005–2013)	30	26 (2005–2017)
P4.4 Children aged 6–59 months covered with two annual doses of vitamin A supplements in vitamin A-priority countries	68% (2011)	80%	64% (2016)
P4.5 Children aged 6–59 months affected by severe acute malnutrition (SAM) reached with quality treatment, defined as children who recovered	Admissions: 2.7 million (2012) Recovered: 85% (2012)	Admissions: 4 million Recovered: >75%	Admissions: 4 million Recovered: 81%

*2013 unless otherwise indicated. **or data from the most recent year available.

Output a

Enhanced support for children, caregivers and communities for improved nutrition and care practices

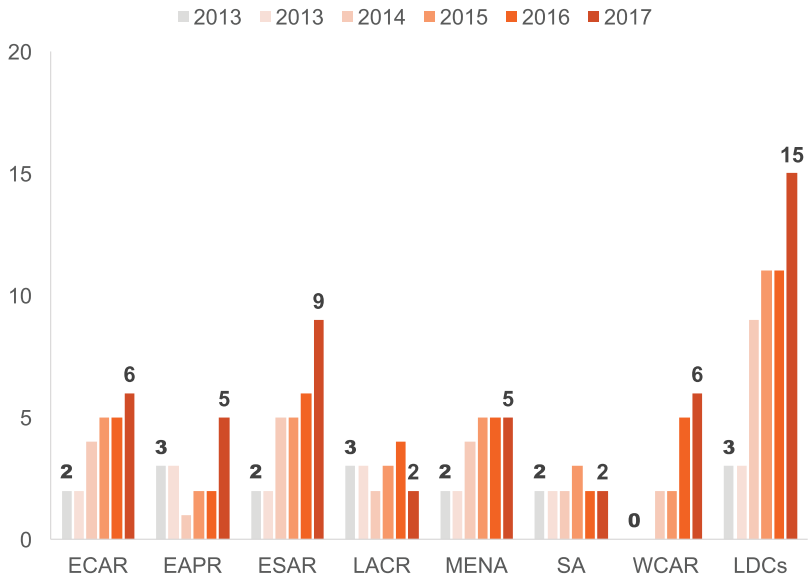
Average output achievement

88%

P4.a.1

Countries with capacities to provide infant and young child feeding counselling services to at least 70% of communities

2013 Baseline	14
2014 Result	20
2015 Result	25
2016 Result	29
2017 Result	35
2017 Target	40



Output b

Increased national capacity to provide access to nutrition interventions

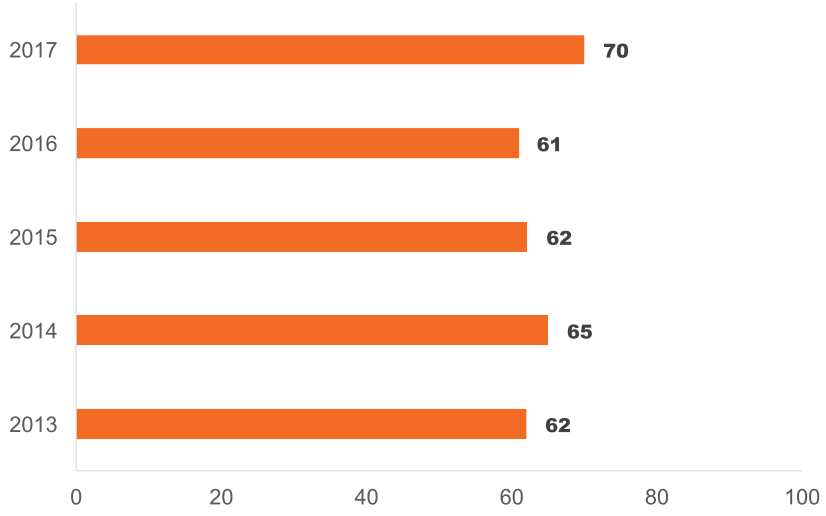
Average output achievement

85%

P4.b.1

Countries with sufficient supply to provide two annual doses of vitamin A supplements to all children aged 6–59 months

2013 Baseline	62
2014 Result	65
2015 Result	62
2016 Result	61
2017 Result	70
2017 Target	82



Output c

Strengthened political commitment, accountability and national capacity to legislate, plan and budget for the scaling-up of nutrition interventions

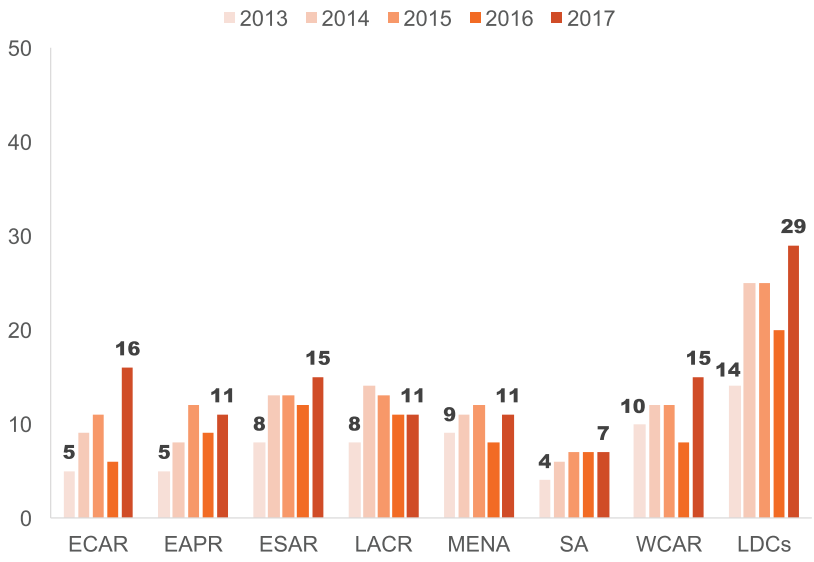
Average output achievement

82%

P4.c.1

Countries in which the International Code of Marketing of Breast-milk Substitutes is adopted as legislation

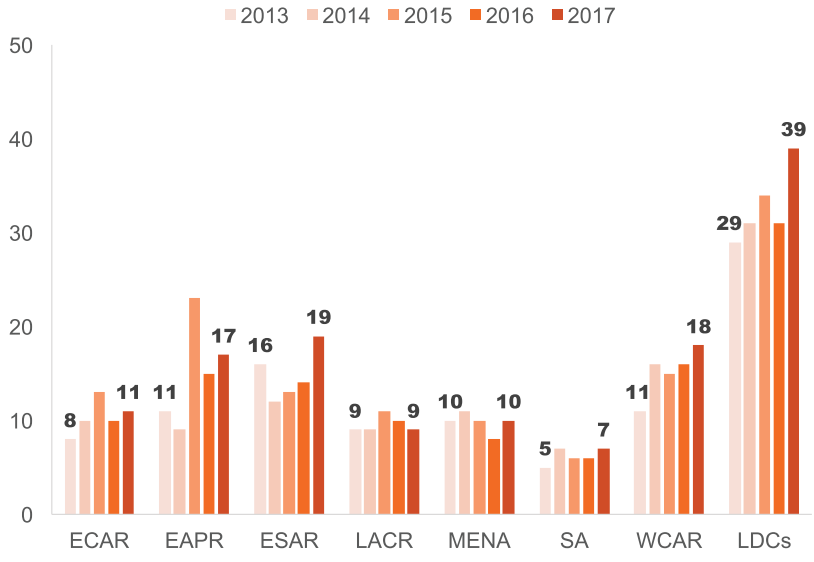
2013 Baseline	64
2014 Result	73
2015 Result	80
2016 Result	61
2017 Result	86
2017 Target	85



P4.c.2 (a)

Countries with a policy or plan targeting anaemia reduction in women

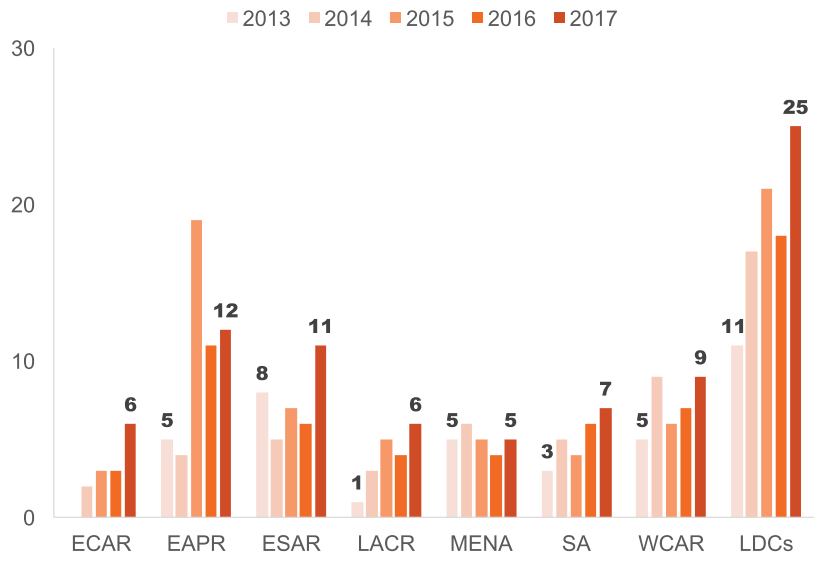
2013 Baseline	70
2014 Result	74
2015 Result	91
2016 Result	79
2017 Result	91
2017 Target	100



P4.c.2 (b)

Countries with a policy or plan targeting anaemia reduction in girls

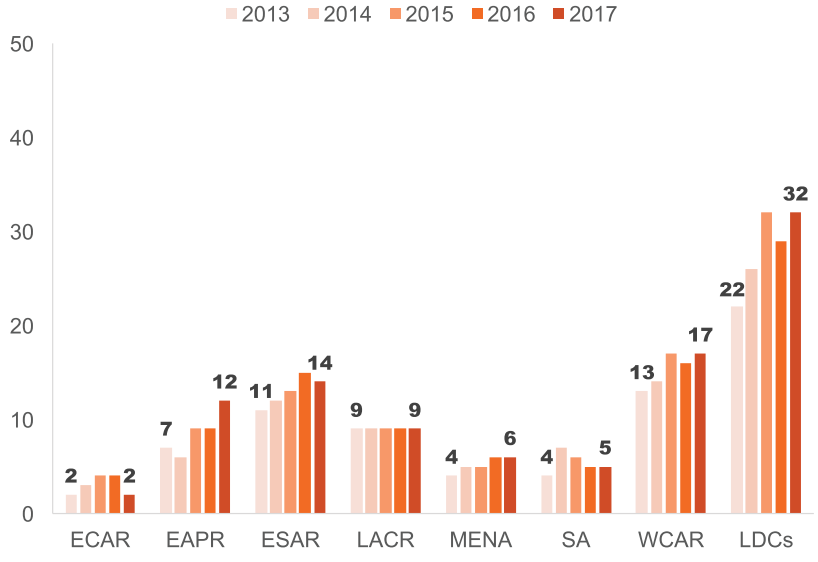
2013 Baseline	27
2014 Result	34
2015 Result	49
2016 Result	41
2017 Result	56
2017 Target	50



P4.c.3

Countries that have developed or revised a nutrition sector plan or policy that includes a risk-management strategy to address disaster/crisis risks (e.g., natural disaster/climate/conflict)

2013 Baseline	50
2014 Result	56
2015 Result	63
2016 Result	64
2017 Result	65
2017 Target	70

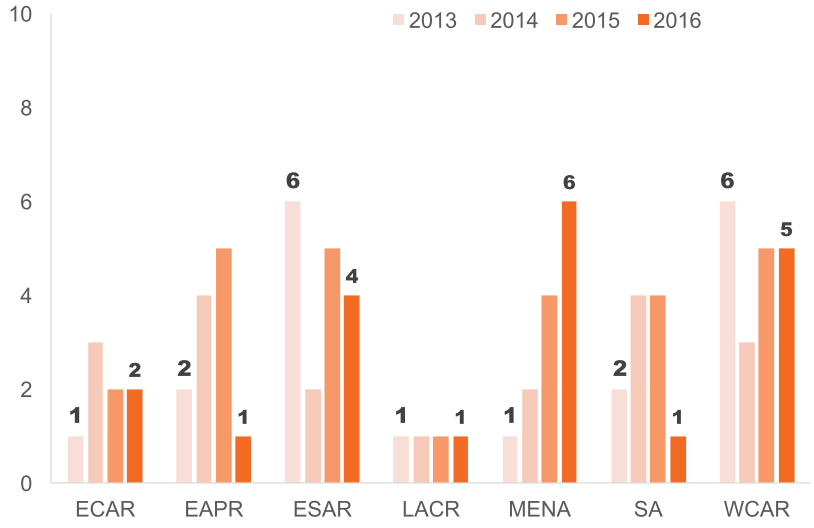


P4.c.4

Countries with a national iodine deficiencies disorder coordination body that was functioning effectively over the previous year

2013 Baseline	19
2014 Result	19
2015 Result	26
2016 Result	20
2017 Result	—
2017 Target	45

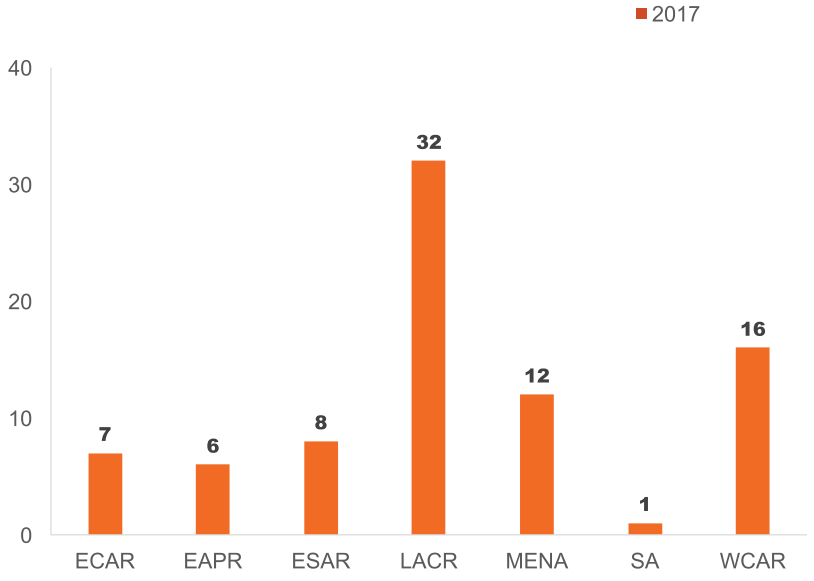
Note: Latest available data from NutriDash are from 2016



P4.c.5

Countries that have legislation to mandate fortification of at least one industrially milled cereal grain

2013 Baseline	78
2014 Result	82
2015 Result	85
2016 Result	86
2017 Result	82
2017 Target	90



Output d

Increased country capacity and delivery of services to ensure the protection of the nutritional status of girls, boys and women from the effects of humanitarian situations

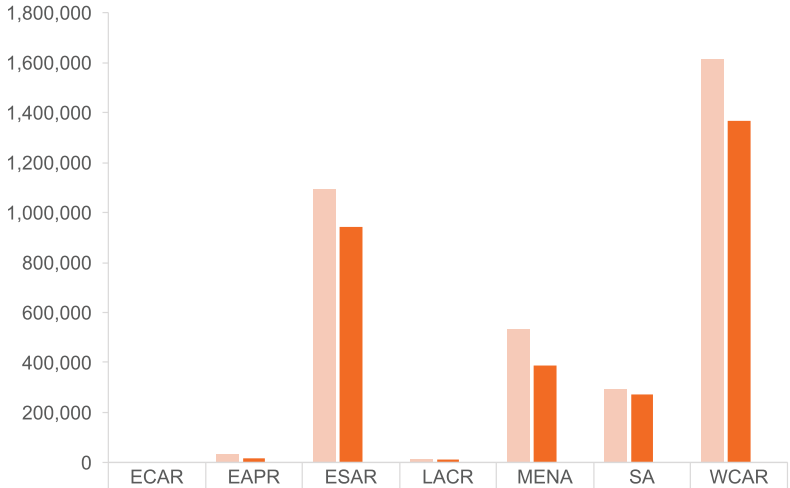
Average output achievement

82%

P4.d.1 (a)

UNICEF-targeted children aged 6–59 months with SAM in humanitarian situations who are admitted to programmes for the management of acute malnutrition

2014 Baseline	81%
2015 Result	65%
2016 Result	72%
2017 Result	83%
2017 Target	95%

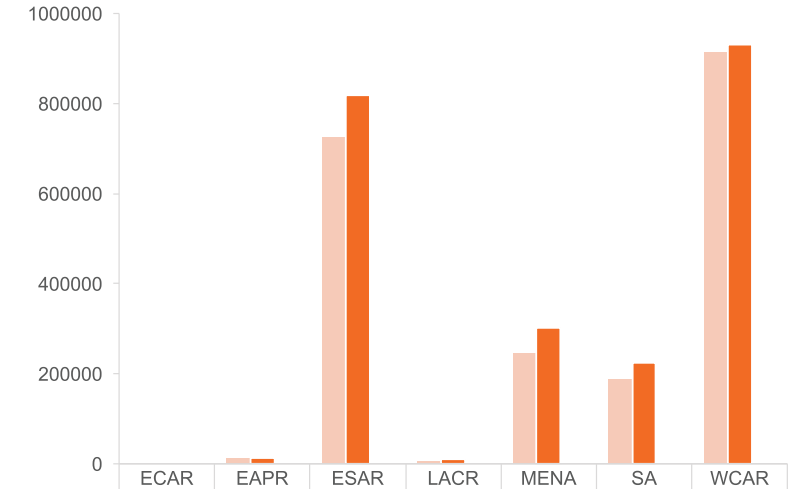


	ECAR	EAPR	ESAR	LACR	MENA	SA	WCAR
Targeted	0	33,348	1,093,923	13,056	534,848	291,997	1,615,187
Admitted	0	15,024	940,067	11,330	389,200	271,768	1,367,117
% admitted	–	45	86	87	73	93	85

P4.d.1 (b)

UNICEF-targeted children aged 6–59 months with SAM in humanitarian situations who are admitted to programmes for the management of acute malnutrition and recover

2014 Baseline	87%
2015 Result	86%
2016 Result	87%
2017 Result	91%
2017 Target	>75%

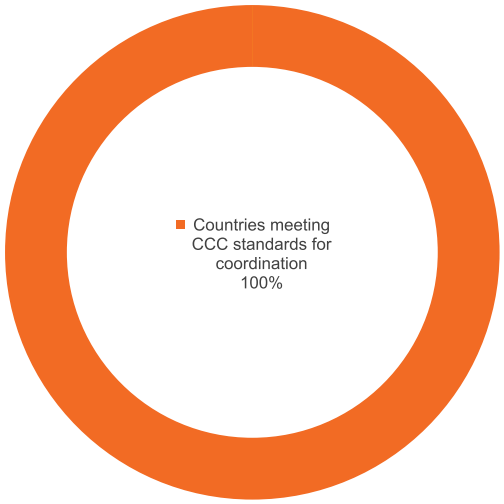


	ECAR	EAPR	ESAR	LACR	MENA	SA	WCAR
Recovered	0	12,146	725,477	6,355	244,749	188,140	912,846
Discharged	0	14,224	818,056	8,950	301,003	223,122	931,009
% recovered	–	85	89	71	81	84	98

P4.d.2

Countries in humanitarian action in which the country cluster coordination mechanism for nutrition meets CCC standards for coordination

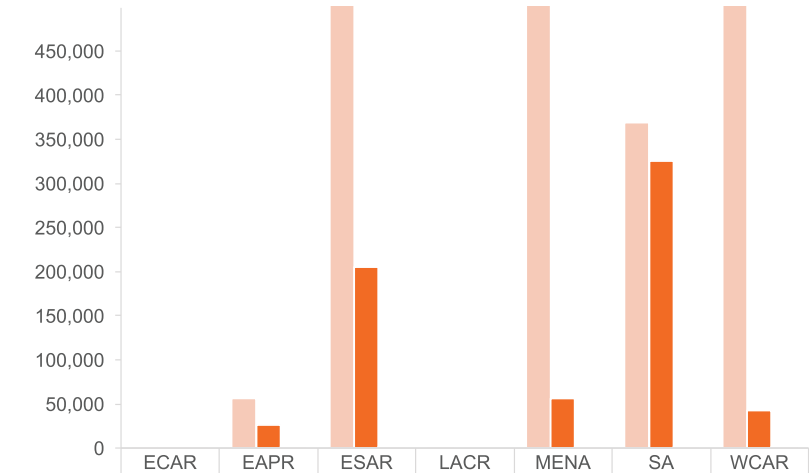
2014 Baseline	100%
2015 Result	93%
2016 Result	93%
2017 Result	100%
2017 Target	100%



P4.d.3

UNICEF-targeted caregivers of children aged 0–23 months in humanitarian situations who are accessing infant and young child feeding counselling that includes early childhood stimulation and development services

2014 Baseline	45%
2015 Result	16%
2016 Result	13%
2017 Result	11%
2017 Target	55%



	ECAR	EAPR	ESAR	LACR	MENA	SA	WCAR
Targeted	1,630	56,318	2,422,791	2,000	2,026,402	368,946	1,115,878
Reached	1,026	26,054	205,408	0	55,821	325,946	42,564
% reached	63	46	8	0	3	88	4

Output e

Increased capacity of Governments and partners, as duty-bearers, to identify and respond to key human-rights and gender-equality dimensions of nutrition

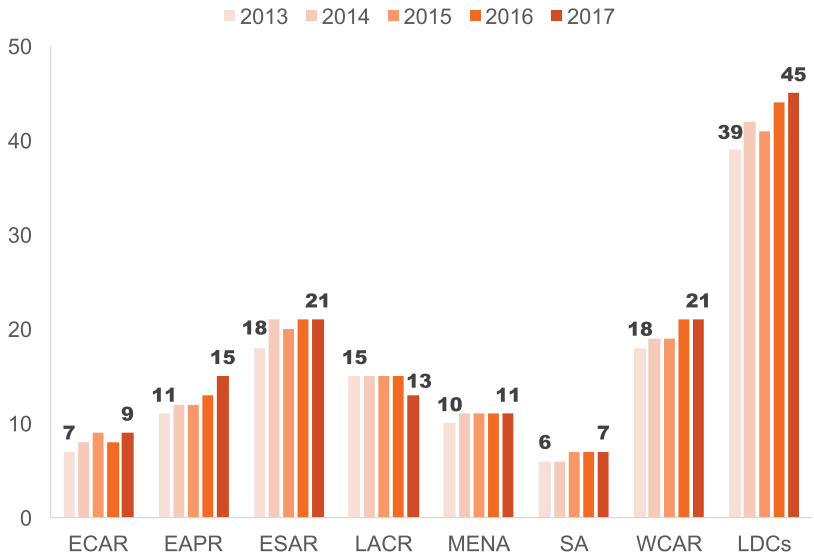
Average output achievement

65%

P4.e.1

Countries with national management information systems that disaggregate data on nutrition

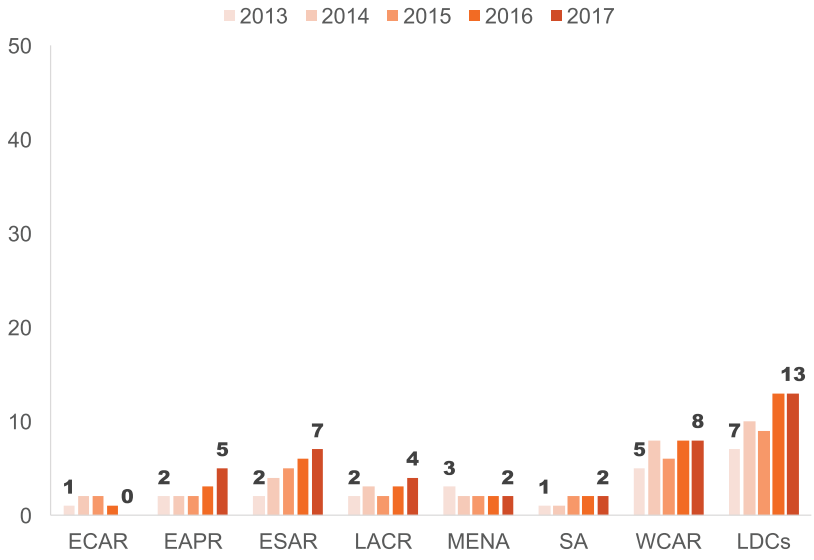
2013 Baseline	85
2014 Result	92
2015 Result	93
2016 Result	96
2017 Result	97
2017 Target	100



P4.e.2

Countries that have undertaken a gender review of the nutrition policy/ strategy in the current national development plan cycle with UNICEF support

2013 Baseline	16
2014 Result	22
2015 Result	21
2016 Result	25
2017 Result	28
2017 Target	40



Output f

Enhanced global and regional capacity to accelerate progress in child nutrition

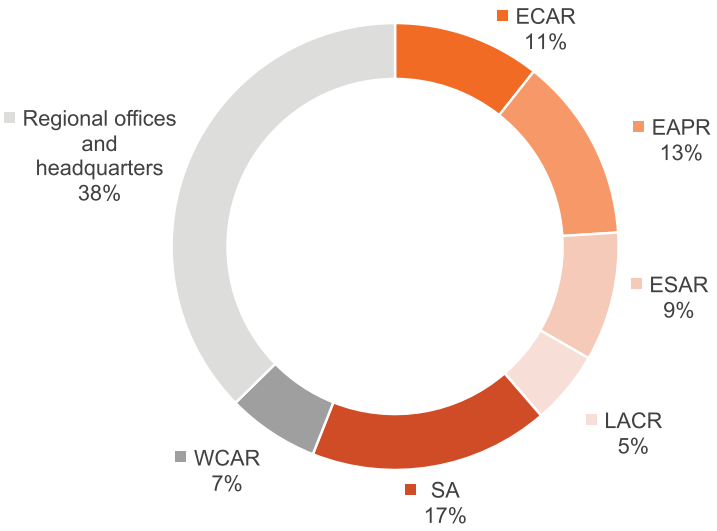
Average output achievement

135%

P4.f.1

Peer-reviewed journal or research publications by UNICEF on nutrition in children and women

2014 Baseline	45
2015 Result	59
2016 Result	55
2017 Result	75
2017 Target	50



P4.f.2

Key global and regional nutrition initiatives in which UNICEF is the co-chair or provides coordination support

2013 Baseline	6
2014 Result	9
2015 Result	14
2016 Result	14
2017 Result	12
2017 Target	10

Global partnerships and initiatives

- Food Fortification Initiative
- Global Alliance for Vitamin A
- Global Breastfeeding Collective
- Global Nutrition Cluster
- Home Fortification Technical Advisory Group
- Infant and Young Child Feeding in Emergencies Core Group
- Iodine Global Network
- Micronutrient Forum
- Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly Resolutions (NetCode)
- No Wasted Lives
- Scaling Up Nutrition (SUN Movement)
- UN Network for SUN (Renewed Efforts Against Child Hunger and undernutrition/United Nations System Standing Committee on Nutrition)

ANNEX 2: LIST OF UNICEF PARTNERS FOR NUTRITION, 2017

Partner (active in two or more countries)	Category
Cornell University	Academia
Harvard University	Academia
Institut de Recherche pour le Développement	Academia
International Food Policy Research Institute	Academia
Johns Hopkins University	Academia
Liverpool School of Tropical Medicine	Academia
Nelson Mandela Metropolitan University	Academia
Universities in programme countries (various)	Academia
Australia	Donor partner
Austria	Donor partner
Belgium	Donor partner
Brazil	Donor partner
Canada	Donor partner
Denmark	Donor partner
Estonia	Donor partner
European Commission	Donor partner
Finland	Donor partner
France	Donor partner
Germany	Donor partner
Global Alliance for Vaccines and Immunisation	Donor partner
Iceland	Donor partner
Ireland	Donor partner
Italy	Donor partner
Japan	Donor partner
Kuwait	Donor partner
Luxembourg	Donor partner
Netherlands	Donor partner
New Zealand	Donor partner

Partner (active in two or more countries)	Category
Norway	Donor partner
Nutrition International	Donor partner
Republic of Korea	Donor partner
Russian Federation	Donor partner
Saudi Arabia	Donor partner
Spain	Donor partner
Sweden	Donor partner
Switzerland	Donor partner
United Kingdom	Donor partner
Turkey	Donor partner
United States of America	Donor partner
Agency for Cooperation and Research in Development	NGO
Acted Agency for Technical Cooperation and Development	NGO
Action Contre la Faim	NGO
Akvo	NGO
Al-Ameen for Humanitarian Support	NGO
ALIMA	NGO
American Refugee Committee	NGO
Comitato Internazionale per lo Sviluppo dei Popoli	NGO
Concern Worldwide	NGO
Global Alliance for Improved Nutrition	NGO
Groupe de Recherches et d'Echanges Technologiques	NGO
Hellen Keller International	NGO
Health Poverty Action	NGO
The International Baby Food Action Network	NGO
International Emergency Development Agency Relief	NGO
INTERSOS	NGO
International Rescue Committee	NGO
MEDAIR	NGO
Médecins du Monde	NGO
Physicians Across Continents	NGO
Qatar Red Crescent	NGO
Relief International	NGO

Partner (active in two or more countries)	Category
Save the Children	NGO
Syria Relief and Development	NGO
Hospital for Sick Children	NGO
World Relief	NGO
World Vision International	NGO
Food Fortification Initiative	Partnership
Global Alliance for Vitamin A	Partnership
Global Breastfeeding Collective	Partnership
Global Nutrition Cluster	Partnership
Global Nutrition Report (stakeholder and expert groups)	Partnership
Home Fortification Technical Advisory Group	Partnership
Infant and Young Child Feeding in Emergencies Core Group	Partnership
Iodine Global Network	Partnership
Micronutrient Forum	Partnership
Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly Resolutions (NetCode)	Partnership
No Wasted Lives	Partnership
Scaling Up Nutrition (SUN Movement)	Partnership
United Nations Network for SUN	Partnership
Bill & Melinda Gates Foundation	Private Sector
CDC Foundation	Private Sector
Partners in Health	Private Sector
Pampers	Private sector
Rotary International	Private Sector
United Nations Foundation Inc.	Private Sector
Australian Committee for UNICEF Limited	UNICEF National Committee
Belgian Committee for UNICEF	UNICEF National Committee
Canadian UNICEF Committee	UNICEF National Committee
Consolidated Funds from National Committees	UNICEF National Committee
Danish Committee for UNICEF	UNICEF National Committee
French Committee for UNICEF	UNICEF National Committee
German Committee for UNICEF	UNICEF National Committee
Hong Kong Committee for UNICEF	UNICEF National Committee

Partner (active in two or more countries)	Category
Italian National Committee for UNICEF	UNICEF National Committee
Japan Committee for UNICEF	UNICEF National Committee
Dutch Committee for UNICEF	UNICEF National Committee
New Zealand Committee for UNICEF	UNICEF National Committee
Norwegian Committee for UNICEF	UNICEF National Committee
Spanish Committee for UNICEF	UNICEF National Committee
Swedish Committee for UNICEF	UNICEF National Committee
Swiss Committee for UNICEF	UNICEF National Committee
UNICEF Ireland	UNICEF National Committee
United Kingdom Committee for UNICEF	UNICEF National Committee
United States Fund for UNICEF	UNICEF National Committee
Food and Agriculture Organization	United Nations
International Fund for Agricultural Development	United Nations
UN Habitat	United Nations
UN Office Geneva	United Nations
UNAIDS	United Nations
United Nations Development Programme	United Nations
United Nations Population Fund	United Nations
United Nations High Commissioner for Refugees	United Nations
United Nations Joint Programme	United Nations
United Nations Standing Committee on Nutrition	United Nations
United Nations Office for the Coordination of Humanitarian Affairs	United Nations
United Nations Office for Project Services	United Nations
United Nations Trust Fund for Human Security	United Nations
World Food Programme	United Nations
World Health Organization	United Nations
World Bank Group – International Development Association (IDA)	United Nations

ANNEX 3: FINANCIAL REPORT*

Financial resources to support nutrition work grew steadily throughout the UNICEF Strategic Plan, 2014–2017, from US$484 million in 2014 to US$665 million in 2017. This annex presents a financial picture of revenue and expenditures in 2017, including: total revenue for UNICEF in all sectors; resources specifically for nutrition; expenditures for nutrition; future funding gap; and a description of the value for money offered by UNICEF's nutrition programmes.

Revenue for UNICEF

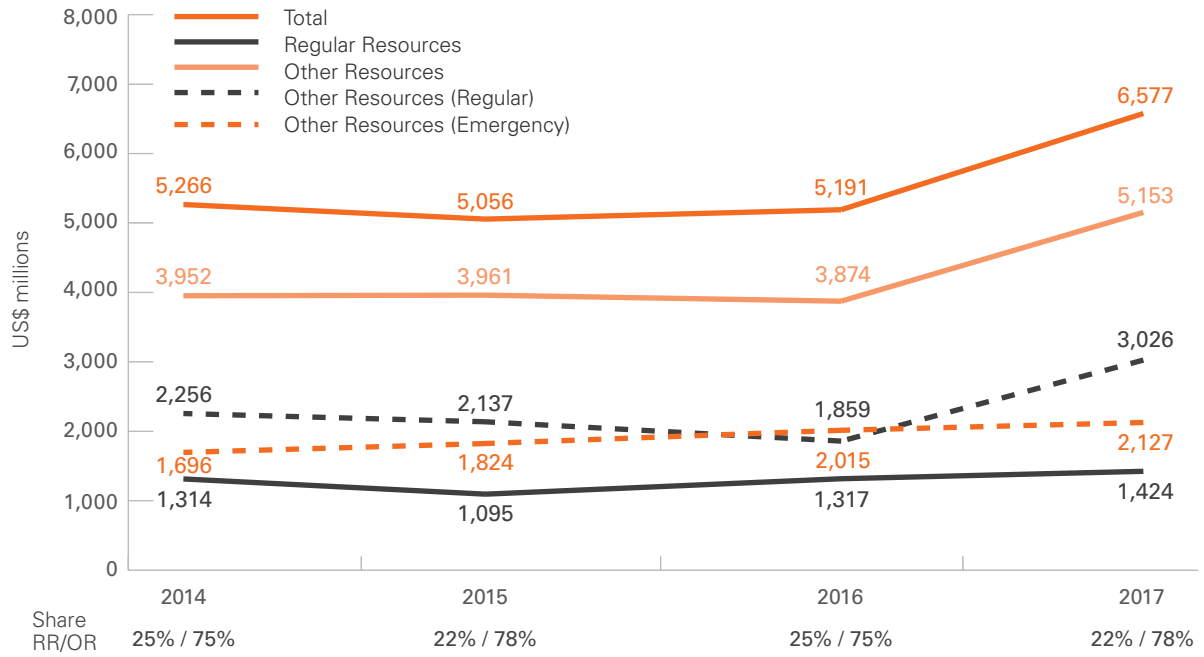
Total revenue to UNICEF – for all sectors, including nutrition – increased in 2017 compared with previous years (*see Figure A1*). Funds earmarked for specific UNICEF programmes (known as 'other resources') grew by 33 per cent from 2016, reaching an all-time high of US$5.153 billion.

This was largely due to the cooperation agreement signed with the World Bank Group – International Development Association (IDA) for Yemen, and the revision of UNICEF's accounting policy, which recognizes revenue at the date that an agreement is signed.

UNICEF's total regular resources also increased in 2017, by 8 per cent, from US$1.317 billion to US$1.424 billion; however, as a proportion of total revenue to UNICEF, regular resources decreased to 22 per cent, from 25 per cent in 2016.

Revenue refers to the total amount committed in the year the agreement was signed plus any adjustments, while contributions refers to disbursements received in a particular year, inclusive of adjustments.

FIGURE A1: Revenue by funding type, 2014–2017



2014–2016 revenue restated to reflect change in accounting policy for comparison with 2017.

** All funding data as of 1 April 2018, pending auditing and certification.*

In 2017, contributions from other resources rose by 19 per cent over 2016, while contributions to the nine thematic funding pools grew more conservatively, by 16 per cent, from US$312 million to US$363 million.

Thematic funding has declined as a percentage of all other resources to just 8 per cent, from a high of 21 per cent in 2010. Thematic funding remains a critical source of revenue for UNICEF programme delivery.

UNICEF resources at a glance

Regular resources (RR): Un-earmarked funds that are foundational to delivering results across the strategic plan.

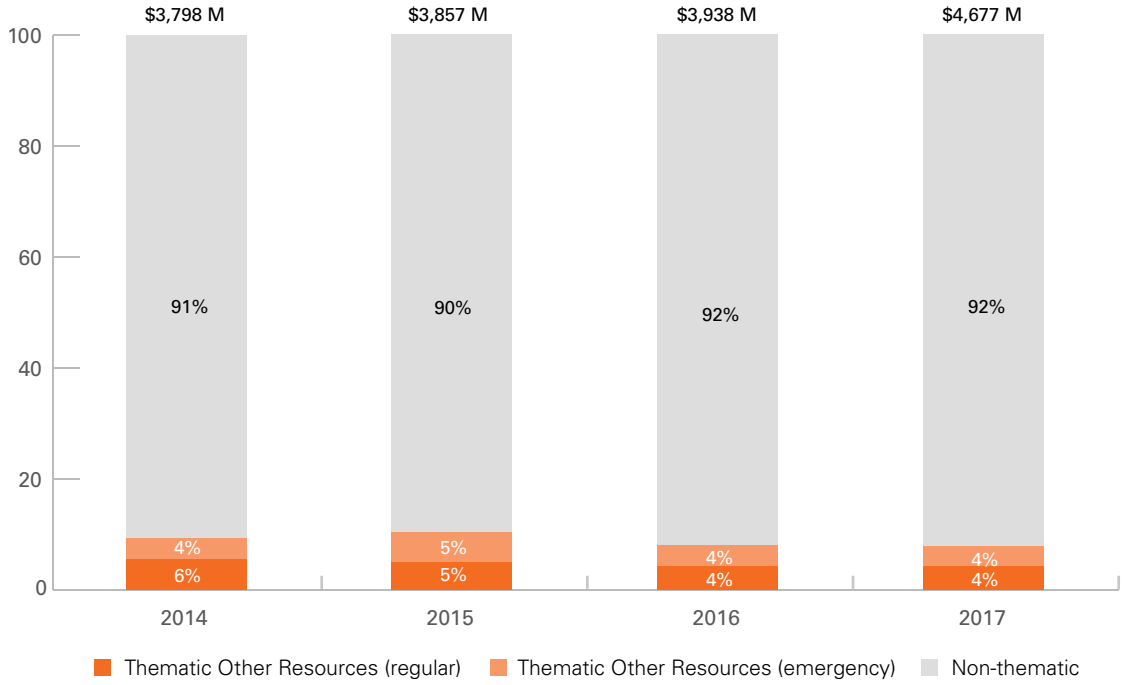
Other resources (OR): Earmarked contributions for programmes; supplementary to regular resources and made for a specific purpose, such as an emergency response or a specific programme in a country/region.

Other resources – regular (ORR): are funds for specific, non-emergency programme purposes and strategic priorities.

Other resources – emergency (ORE): are funds earmarked for specific humanitarian action and post-crisis recovery activities.

Thematic resources: Flexible, un-earmarked funds, allowing for longer-term planning and programme sustainability. This is the preferred funding modality after regular resources.

FIGURE A2: All other resources contributions 2014–2017: Share of thematic funding

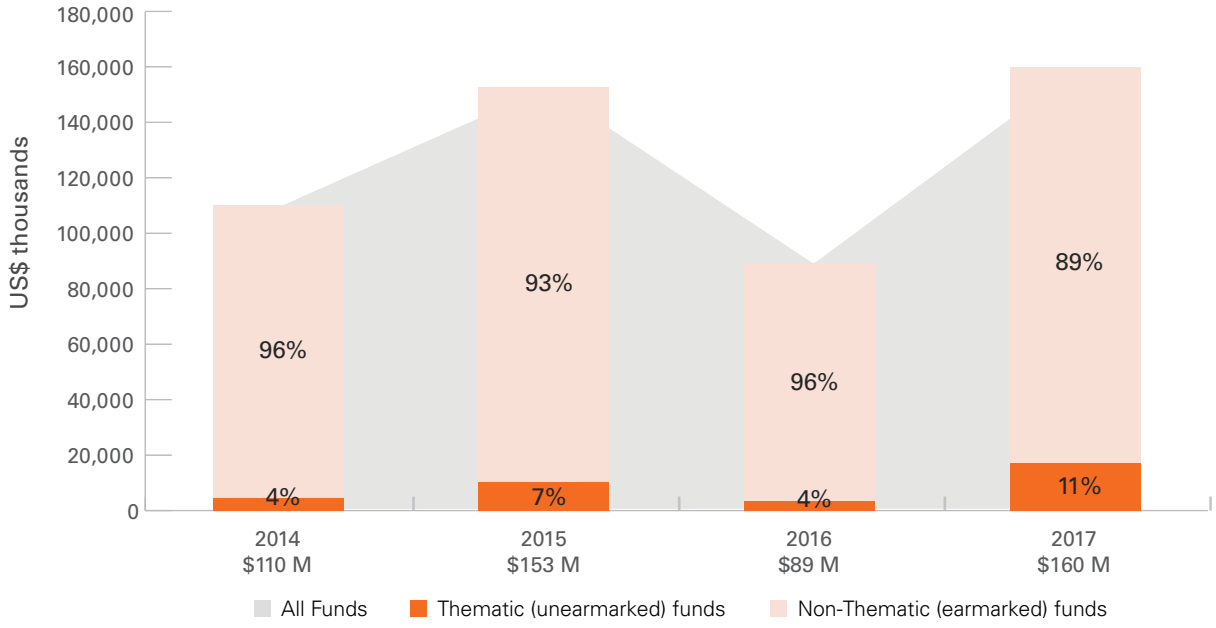


2014–2016 contributions received restated to reflect change in accounting policy for comparison with 2017.

Resources for nutrition

In 2017, partners contributed US$160 million other resources for nutrition, an 80 per cent increase from the previous year (*see Figure A3*). The top five resource partners to UNICEF Nutrition in 2017 included the World Bank Group – IDA, Germany, the United Kingdom, the Netherlands and the European Commission (*see Table A1*). Table A1 shows that the largest contributions were received from the World Bank Group – IDA, for emergency health and nutrition in Yemen; and from Germany, for coping with the effects of drought in Ethiopia and resilience strengthening in Somalia (*see 'Programme Area 3' for details on these programmes*). At the end of the year, the first global thematic contribution for nutrition was also received from the Netherlands for 2018 programming (*see page 81-82*).

FIGURE A3: Nutrition other resources contributions, 2014–2017



**Regular resources are not included, as they are not linked to any single outcome or cross-cutting area at the time of contribution by a partner.*

TABLE A1: Top 20 resources partners to UNICEF Nutrition by total contribution, 2017

Rank	Resource partners	Total (US$)
1	World Bank Group – IDA	63,180,263
2	Germany*	37,437,296
3	The United Kingdom	24,002,623
4	The Netherlands*	22,802,307
5	European Commission	22,008,561
6	United Kingdom Committee for UNICEF	16,870,565
7	U.S. Fund for UNICEF	10,700,676
8	Japan*	7,527,739
9	United States of America*	6,994,192
10	Food and Agriculture Organization of the United Nations	4,671,211
11	Republic of Korea	4,100,000
12	Swedish Committee for UNICEF	3,449,013
13	French Committee for UNICEF	2,000,944
14	Ireland*	1,487,550
15	World Food Programme	1,212,082
16	Nutrition International	1,072,559
17	Spanish Committee for UNICEF	863,336
18	Luxembourg	658,129
19	Italy	542,888
20	Polish Committee for UNICEF	516,459

**Includes cross-sectoral grants SC170533 (WASH, Nutrition and Health), SC170004 (Nutrition, WASH, Education, Child Protection and Social Inclusion), SC170114 (Health and Nutrition), SC170094 (Health, Nutrition and WASH), SC160336 (Health and Nutrition), SC150579 (Nutrition and Social Inclusion) and SC140860 (Nutrition and Education).*

TABLE A2: Top 10 contributions to Nutrition, 2017

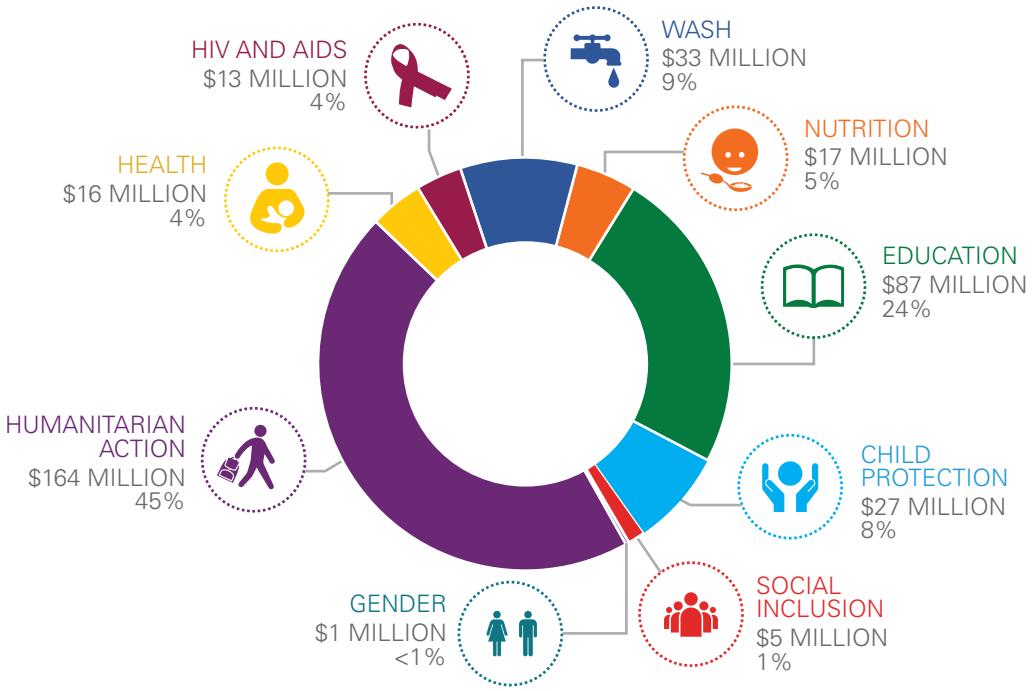
Rank	Resource partners	Grant description	Total (US$)
1	World Bank Group – IDA	Additional financing for emergency health and nutrition project, Yemen	62,990,000
2	Germany*	Contribution to longer-term coping with drought effects, Ethiopia	17,688,679
3	Germany	Strengthening Resilience in Somalia	17,180,095
4	Netherlands	Nutrition, global thematic funding (for 2018)	14,000,000
5	United Kingdom Committee for UNICEF	Community management of acute malnutrition, Nigeria	12,142,375
6	United Kingdom	Accelerating the reduction of undernutrition, Ethiopia	9,655,984
7	Netherlands*	Developing human capital, Rwanda	8,802,307
8	Japan*	Improving maternal & child health and nutritional status, Yemen	6,891,739
9	European Commission	Nutrition, Mozambique	6,479,636
10	United Kingdom	Improving Newborn and child nutrition, northern Nigeria	5,770,922

**Cross-sectoral grants SC170533 (WASH, Nutrition and Health), SC170004 (Nutrition, WASH, Education and Social Inclusion) and SC170114 (Health and Nutrition).*

Thematic resources act as an ideal complement to regular resources. They are allocated on the basis of need and allow for long-term planning and programme sustainability. With a funding pool for each of the strategic plan outcome areas as well as humanitarian action and gender equality, resource partners can contribute thematic funding at the global, regional or country level. Global thematic funds are the most flexible source of funding to UNICEF after regular resources. Thematic contributions allow UNICEF to invest in longer-term systems strengthening and resilience building, particularly in fragile contexts – work that is critical to bridging the divide between humanitarian and development programming.

Overall contributions to UNICEF's thematic funding pools increased from US$312 million in 2016 to US$363 million in 2017. The largest public-sector contributors to the thematic funding pools in 2017 were Norway, Sweden, the Netherlands and Denmark, while the largest private-sector contributions were facilitated by the German Committee for UNICEF and the United States Fund for UNICEF. A complete financial statement of thematic funding contributions and expenditures is annexed to this report. For more information on thematic funding, please visit: www.unicef.org/publicpartnerships/66662_66851.html.

FIGURE A4: Thematic contributions by outcome area and humanitarian action, 2017



Thematic funding contributions for nutrition reached US$17 million in 2017, a 410 per cent increase from the US$3.38 million received in 2016. This included a modest growth of country- and region-specific thematic funding. The bulk of the increase is due to a US$14 million contribution from the Netherlands (received in December 2017 to be used in 2018) – the first instalment of a multi-year global thematic funding agreement, which will eventually total US$56 million over the 2018–2021 period. UNICEF has a long history of partnership with the Government of the Netherlands for nutrition programmes, but this marks the first thematic funding collaboration. UNICEF is extremely grateful for the opportunity to build on the achievements of its previous partnerships with the Government of the Netherlands. With these thematic resources, UNICEF Nutrition will launch the 2018–2021 strategic plan with the financial security and flexibility needed to engage in true long-term planning and programming.

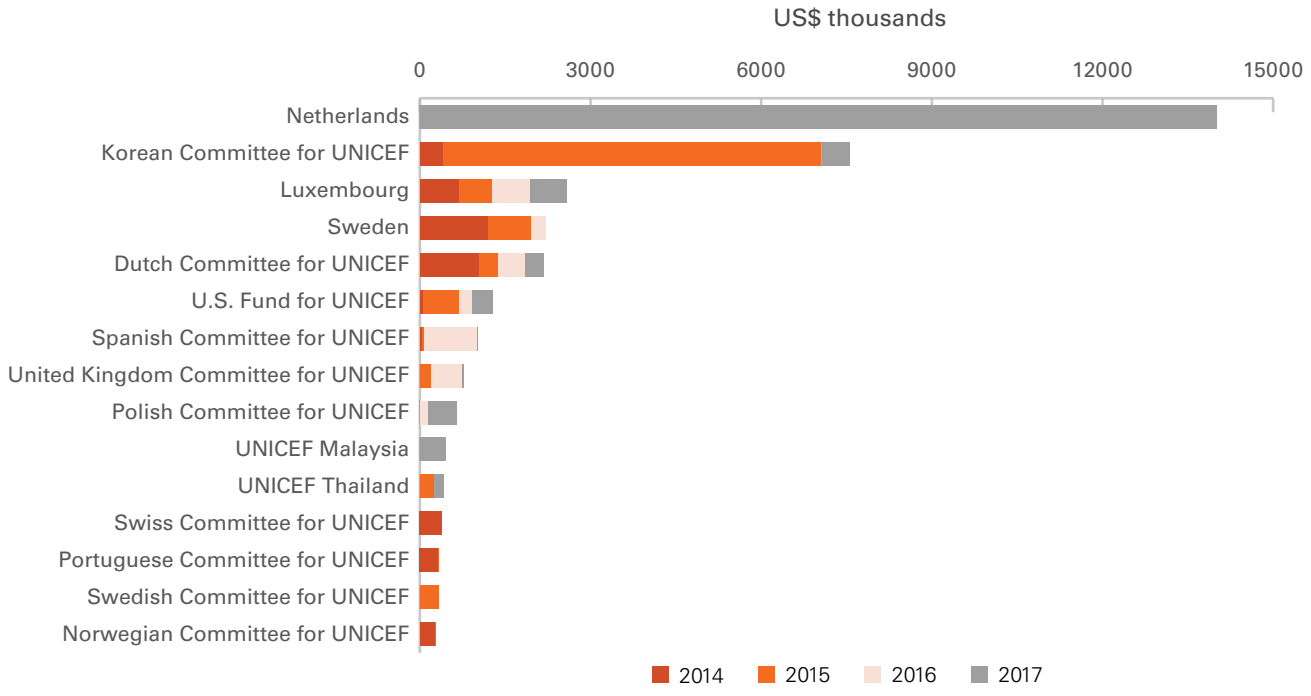
The number of partners contributing thematic funding to nutrition increased from 10 in 2016 to 13 in 2017, thanks in part to new fundraising efforts by UNICEF offices in Malaysia and Thailand (*see Table A3 and Figure A5*). Thematic contributions were also received from the Dutch and Korean Committees for UNICEF, the Polish National Committee for UNICEF and the United States Fund for UNICEF. Of these, only the Netherlands and the United States provided funding at the global level, while Korea and Poland earmarked their thematic contributions to West and Eastern African countries and regional activities, Mongolia and Guatemala, in no specific order (*see Figure A6*). UNICEF is seeking to broaden and diversify its funding base (including thematic contributions) and encourages all partners to give as flexibly as possible.

TABLE A3: Thematic funding contributions by resource partner to UNICEF Nutrition, 2017

Resource partner type	Resource partner	Total (US$)	Percentage of total
Governments 85.19%	The Netherlands	14,000,000	81.28%
	Luxembourg	658,129	3.82%
	Canada	15,707	0.09%
National Committees 11.10%	Polish Committee for UNICEF	511,280	2.97%
	Korean Committee for UNICEF	500,000	2.90%
	US Fund for UNICEF	362,314	2.10%
	Dutch Committee for UNICEF	344,990	2.00%
	Slovak Committee for UNICEF	74,899	0.43%
	Belgian Committee for UNICEF	51,171	0.30%
	United Kingdom Committee for UNICEF	42,694	0.25%
	Spanish Committee for UNICEF	23,860	0.14%
Field Offices 3.71%	UNICEF Malaysia	450,000	2.61%
	UNICEF Thailand	189,000	1.10%
Grand total		17,224,044	100.00%

Grant numbers are provided for IATI compliance: SC1899030001, SC1499040071, SC1499040023, SC1499040066, SC1499040073, SC1499040044, SC1499040063, SC1499040041, SC1499040057, SC1499040069, SC1499040078, SC1499040070, SC1499040072, SC1499040074, SC1499040065, SC1499040068, SC1499040047, SC1499040075, SC1499040076, SC1499040077.

FIGURE A5: Top 15 thematic funding contributions by resource partners for nutrition, 2014–2017



PARTNER TESTIMONIAL

Luxembourg is a staunch supporter of the United Nations and of multilateralism, devoting around one third of its official development assistance to multilateral agencies. By making multi-year contributions to the various UNICEF thematic funds, Luxembourg continues to be a reliable partner and provides ongoing support to UNICEF. These contributions are intended to aid UNICEF interventions to strengthen basic education, the maternal health system and young child survival and development. Luxembourg's commitment to gender equality – one of the cross-cutting themes of its bilateral cooperation – led to it being the first country to contribute to the UNICEF thematic fund for gender equality in 2016. This commitment reflects its support for ending child marriage, which represents a serious violation of children's rights. Luxembourg has successfully contributed to adoption of the European Union Gender Action Plan and continues to be a strong advocate for this theme on the international stage.

Romain Schneider
Minister for Development Cooperation and Humanitarian Affairs, Luxembourg

The allocation and expenditure of all thematic funding contributions can be monitored on UNICEF's transparency portal open.unicef.org, and the results achieved with these funds against Executive Board approved targets and indicators at the country, regional and global level are consolidated and reported on across the suite of Annual Results Reports.

Specific reporting for country and regional thematic funding contributions is provided separately for partners giving at those levels.

With the nutrition sector, global thematic resources are allocated to critically underfunded regional and country offices according to population need and potential for greatest impact. Within headquarters, thematic funds were used to support resource mobilization and knowledge management and to fund a staff member providing policy guidance to programmes related to nutrition and HIV/AIDS care and support.

FIGURE A6: Nutrition thematic funding contributions at country, regional and global levels, 2014–2017

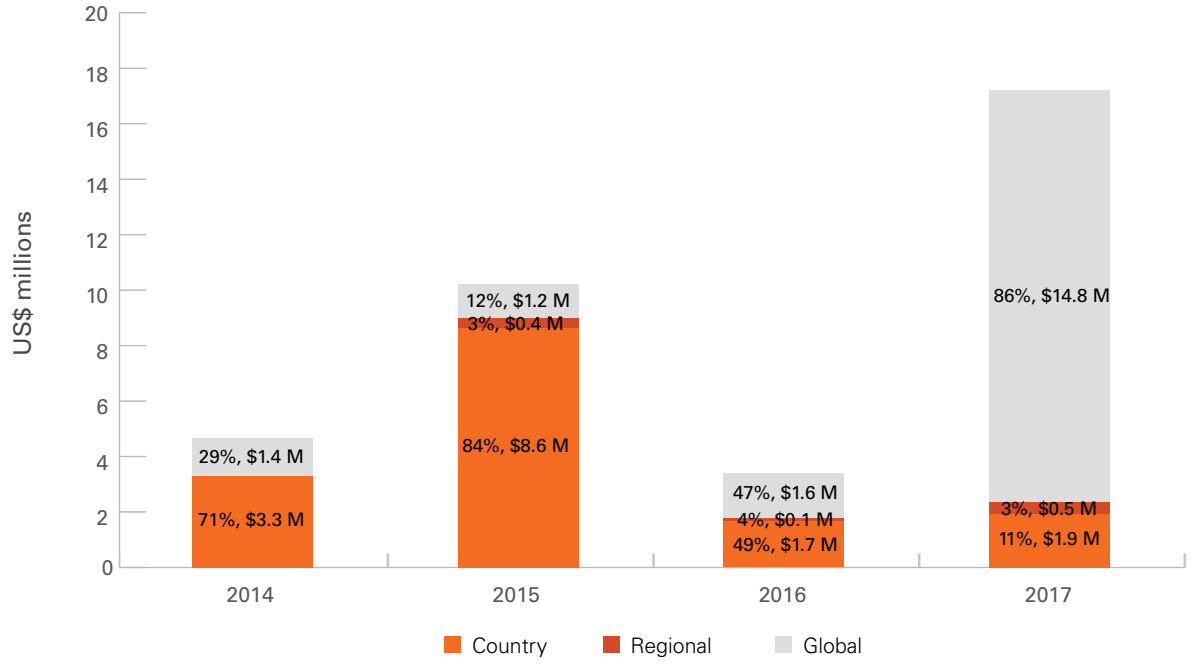


TABLE A4: Allotment of nutrition global thematic funding revenue to offices and programmes, by region, 2017

Region/country	Allotment (US$)	Percentage of total allocation
Country offices	**204,417**	**42%**
Plurinational State of Bolivia	60,000	12%
Tajikistan	20,000	4%
Bosnia and Herzegovina	30,000	6%
Macedonia (The former Yugoslav Republic of)	20,000	4%
Paraguay	20,000	4%
Afghanistan	54,417	11%
Regional offices	**132,334**	**27%**
Regional Office for South Asia	99,534	20%
Regional Office for Americas and the Caribbean	32,800	7%
Headquarters	**149,026**	**31%**
Headquarters	124,672	26%
Headquarters	24,354	5%
Total	485,777	100%

Transparency: follow the flow of funds from contribution to programming by visiting http://open.unicef.org

Expenses for nutrition

Note: Expenses are higher than the contributions received because expenses are comprised of total allotments from regular resources and other resource (including balances carried over from prior years) to the outcome areas, while contributions reflect only funds received from 2016 to the same.

Overall nutrition spending increased throughout the four-year reporting period, peaking at US$665 million in 2017 (*see Figure A7*), from US$624 million the previous year. In particular, resources earmarked for emergencies (other resources – emergency) have increased with each year of the strategic plan to reach US$310 million in 2017, and this has helped UNICEF respond effectively to the increasing scale and scope of humanitarian need (*see Figure A7*).

Expenses vs Expenditure

Expenses are recorded according to International Public Sector Accounting Standards and are accrual-based. These are used for official financial reporting. Expenditures are recorded on a modified cash basis. They are used for budget reporting since they are aligned with cash disbursements and goods receipts (the way budgets are consumed).

FIGURE A7: Expenses trend for nutrition, 2014–2017 (US$ 665 million in 2017)

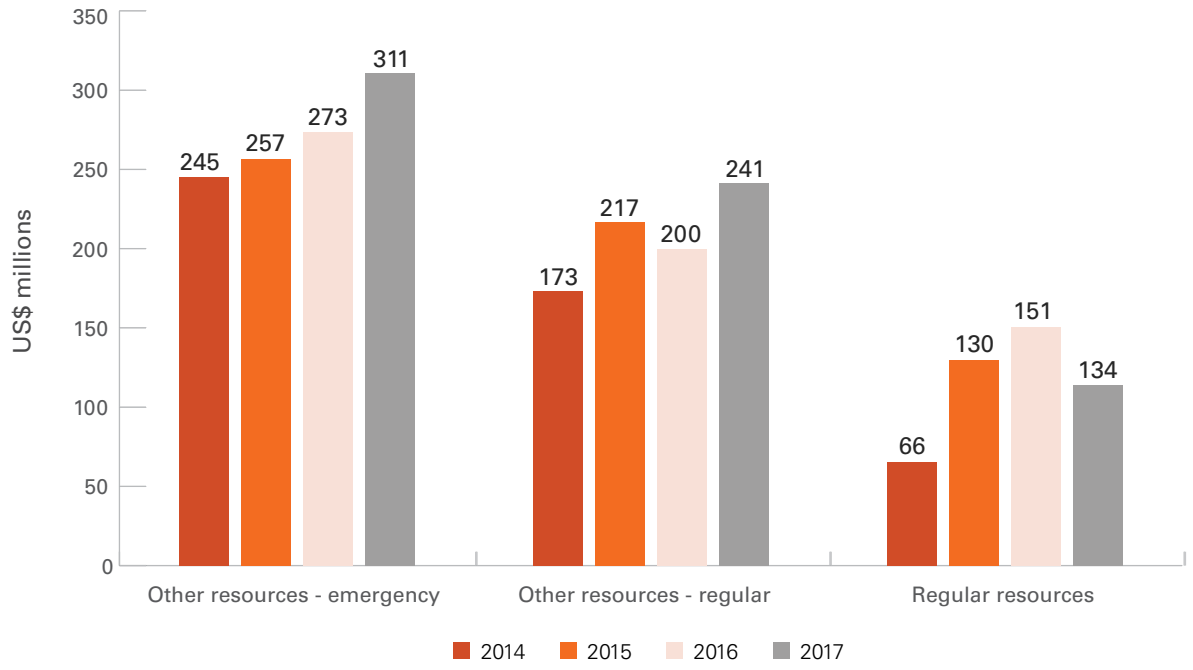
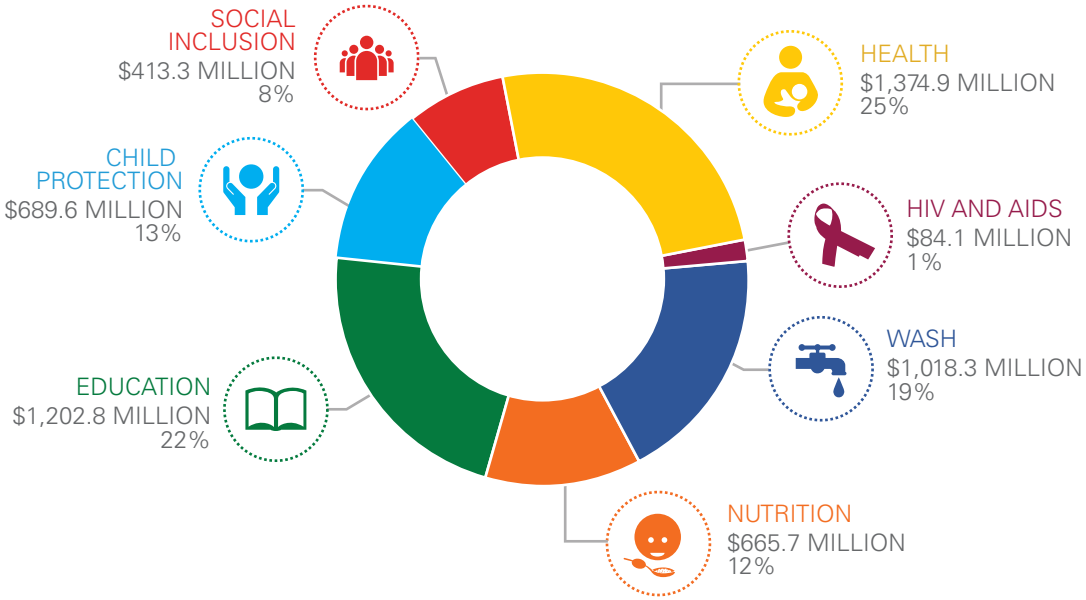
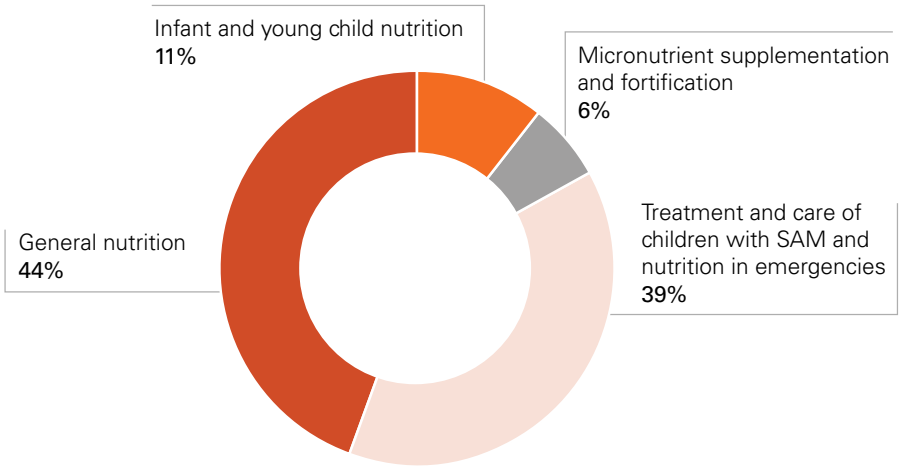


FIGURE A8: Expense by outcome area, 2017 (total = US$5.4 billion)



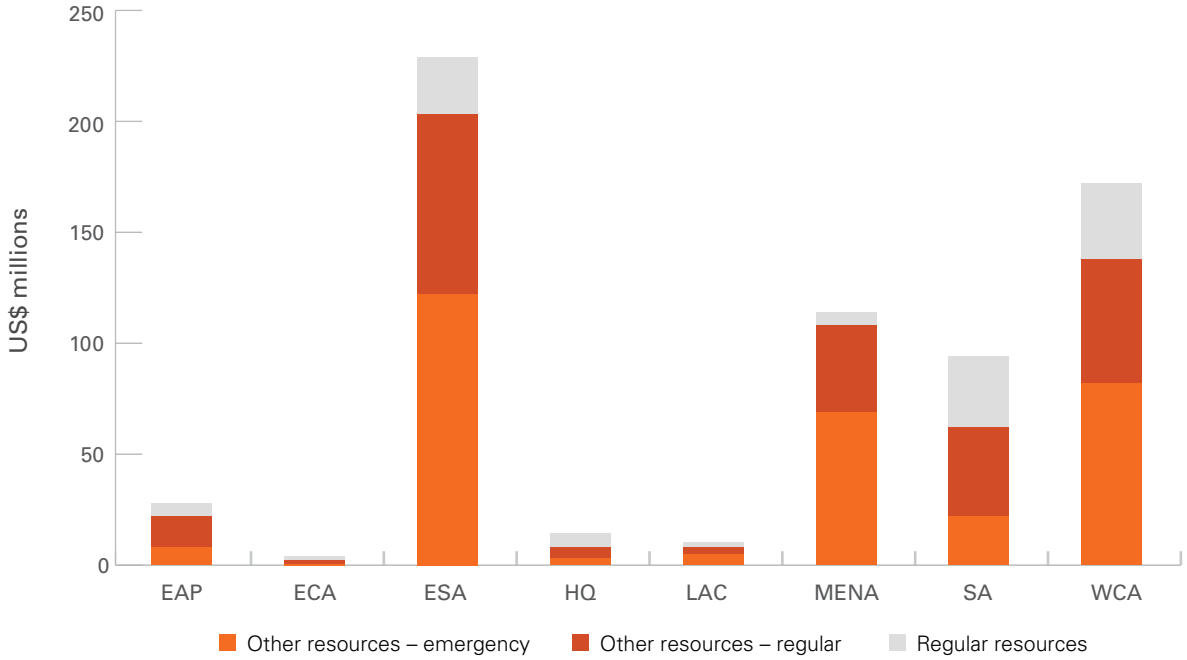
Spending in the nutrition outcome area was 12 per cent of all expenses (*see Figure A8*). In 2017, Programme Area 3 (treatment and care of SAM and nutrition in emergencies) accounted for the greatest programme expenses – US$258 million – followed closely by Programme Area 4 (general nutrition) (*see Figure A9*). This spending pattern recognizes the importance of UNICEF's support to timely and effective response to nutrition emergencies and its obligations specific to fulfilling its Nutrition Cluster Lead Agency role – work that is critical in the context of increasingly complex humanitarian crises. At the same time, there is a need to sustain and increase resources for preventive nutrition interventions – most of those covered in Programme Areas 2 and 3 – in order to break the cycle of undernutrition before it starts.

FIGURE A9: Expense by programme area for nutrition, 2017



As was the case in previous years, most nutrition spending in 2017 supported programming in Eastern and Southern Africa and West and Central Africa (*see Figure A10*). This reflects the high burden of undernutrition in these regions, as well as the humanitarian crises facing a number of countries in 2017, particularly in north-east Nigeria, Somalia and South Sudan. In addition to vital emergency response, greater investments are needed in preparedness and systems strengthening during protracted crises in order to build resilience in fragile settings; flexible resources would further support these efforts. There is also an urgent need to boost spending in non-emergency contexts, particularly in South Asia, where the number of children affected by SAM remains high, and resources for treatment and care are limited.

FIGURE A10: Expenses by region and funding source for nutrition, 2017 (total = US$665 million)



EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; HQ, headquarters; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

Table A5 shows the 20 countries where the most money was spent on nutrition in 2017; these countries accounted for 73 per cent of all nutrition expenses. The nutrition spending in these countries makes sense given that 12 of them have either a stunting prevalence greater than or equal to 40 per cent or a wasting prevalence greater than or equal to 10 per cent. Many of these countries faced humanitarian crises in 2017 related to conflict, natural disasters, disease outbreaks and drought, and thus significant funds were allocated to support subnational and national emergency nutrition response.

TABLE A5: Expenses (US$) for nutrition – top 20 countries, 2017

Country	Grand total (US$)
Yemen	74,330,357
Nigeria	50,461,611
Ethiopia	45,778,735
Somalia	36,120,817
South Sudan	35,799,726
Afghanistan	22,706,515
Niger	22,693,725
Kenya	21,996,862
Chad	21,264,402
India	21,112,495
Sudan	20,246,648
Pakistan	17,020,226
Nepal	16,165,278
Malawi	16,000,375
Zimbabwe	14,313,688
Mali	12,958,106
Rwanda	11,126,020
Bangladesh	9,665,380
Democratic Republic of the Congo	9,490,963
Burkina Faso	9,423,957
Total top 20	488,675,886

As in previous years, most of the expenses in the nutrition sector supported the procurement of supplies (*see Table A6*), including RUTF and therapeutic milks, vitamin A capsules, micronutrient powders and tools used in growth monitoring, such as height boards and scales. In 2017, significant investments were made through counterparts and implementing partners to support them in delivering and implementing high-impact nutrition interventions. UNICEF's strategic partnerships allow the organization to target funds effectively and efficiently to ensure wide coverage of interventions, especially in fragile settings where national systems may be weak.

TABLE A6: Expenses (US$) for nutrition by cost category, 2017

Cost category	Total in 2017 (US$)
Supplies and commodities	237,580,307
Transfers and grants to counterparts	205,775,555
Staff and personnel costs	92,750,930
Contractual services	47,562,199
Incremental direct costs	35,981,398
General operation + other direct costs	29,383,246
Travel	14,024,903
Equipment, vehicles and furniture	2,612,779

Funding gaps for nutrition

Investing in nutrition brings significant gains for the development of children and nations. Greater thematic resources for nutrition would allow UNICEF to more efficiently improve long-term planning, increase internal capacity, strengthen knowledge and evidence generation, and react with flexibility to ongoing challenges and new areas of work. UNICEF looks forward to working with its partners to meet these funding needs to deliver results for children and achieve the goals of the 2030 Agenda.

Value for money in nutrition

UNICEF uses a number of strategies to improve value for money in nutrition programming. First, it minimizes the cost of programming, by leveraging the strengths of a range of implementing partners in different contexts and supporting local actors, particularly during emergency responses. Second, UNICEF's programmes prioritize cost efficiency, and many of the most effective nutrition interventions – such as breastfeeding and the provision of essential micronutrients – are both low cost and high impact. Third, UNICEF's spending in nutrition is guided by the principal of equity, helping to bridge gaps and deliver services to the most marginalized children and their families. This approach is not only the most ethical – it also has the greatest potential to save lives.[65]

2017 THEMATIC FUNDS FINANCIAL STATEMENT

STATEMENT OF ACCOUNT AS OF 31 DECEMBER 2017 IN US DOLLARS

CONTRIBUTIONS

Donor	Prior Year(s)	2017	Cumulative
Belgian Committee for UNICEF	143,395.87	51,170.73	194,566.60
Czech Committee for UNICEF	76,169.59	0.00	76,169.59
Danish Committee for UNICEF	12,949.15	0.00	12,949.15
Government of Belgium	270,855.90	0.00	270,855.90
Government of Canada	55,290.58	15,706.57	70,997.15
Government of Luxembourg	1,929,883.06	658,128.77	2,588,011.83
Government of New Zealand	174.47	0.00	174.47
Government of Sweden	2,211,221.55	0.00	2,211,221.55
Iceland National Commdor UNICEF	78,327.94	0.00	78,327.94
Japan Committee for UNICEF	20,744.28	0.00	20,744.28
Korean Committee for UNICEF	9,402,943.00	500,000.00	9,902,943.00
Netherlands Committee for UNICEF	2,174,709.04	344,990.25	2,519,699.29
Norwegian Committee for UNICEF	280,775.04	0.00	280,775.04
Polish National Comm for UNICEF	140,416.58	511,280.21	651,696.79
Portuguese Committee for UNICEF	326,312.10	0.00	326,312.10
Slovak Committee for UNICEF	120,884.22	74,899.18	195,783.40
Slovenska Fundacja Za UNICEF	84,291.72	0.00	84,291.72
Spanish Committee for UNICEF	1,014,123.37	23,859.64	1,037,983.01
Swedish Committee for UNICEF	322,941.25	0.00	322,941.25
Swiss Committee for UNICEF	387,477.77	0.00	387,477.77
UNICEF-Bosnia & Herzegovina	17,906.34	0.00	17,906.34
UNICEF-Malaysia	0.00	450,000.00	450,000.00
UNICEF-Thailand	283,649.40	189,000.00	472,649.40
UNICEF-United Arab Emirates	24,976.18	0.00	24,976.18
United Kingdom Committee for UNICEF	759,358.82	42,694.00	802,052.82
United States Fund for UNICEF	919,621.78	362,313.65	1,281,935.43
Total	**21,059,399.00**	**3,224,043.00**	**24,283,442.00**

EXPENDITURES

Donor	Prior Year(s)	2017	Cumulative
Angola	0.00	1,983.41	1,983.41
Bangladesh	31,086.82	(2,501.07)	28,585.75
Benin	13,670.86	212,252.20	225,923.06
Bhutan	30,110.07	76,175.26	106,285.33
Bolivia	467,694.48	78,289.37	545,983.85
Bosnia and Herzegovina	0.00	31,547.09	31,547.09
Botswana	45,149.24	1,476.37	46,625.61
Burkina Faso	30,175.65	815.27	30,990.92
Cambodia	63,096.00	242.53	63,338.53
Comoros	0.00	25,937.96	25,937.96
Djibouti	175,825.72	95,474.61	271,300.33
Democratic Republic of Korea	5,539,186.31	2,464,607.62	8,003,793.93
EAPRO, Thailand	66,161.44	60,122.30	126,283.74
ECARO, Switzerland	0.00	22,832.98	22,832.98
Ecuador	0.00	32,831.71	32,831.71
Eritrea	19,240.14	157,769.30	177,009.44
ESARO, Kenya	0.00	200,784.68	200,784.68
Ethiopia	385,685.81	124,681.29	510,367.10
Gambia	13,693.37	40,955.88	54,649.25
Guatemala	575,592.26	102,674.73	678,266.99
Guinea	0.00	70,324.58	70,324.58
Indonesia	81,212.36	149,138.67	230,351.03
Kazakhstan	13,626.48	779.95	14,406.43
LACRO, Panama	52,362.43	18,432.27	70,794.70
Lao People's Democratic Republic	50,085.18	154.70	50,239.88
Macedonia	0.00	21,075.99	21,075.99
Madagascar	418,053.52	116,498.55	534,552.07
Malawi	18,776.09	32.53	18,808.62
Maldives	0.00	28,839.28	28,839.28
Mali	131,134.76	4,200.86	135,335.62
Mauritania	94,128.57	168,640.07	262,768.64
MENA, Jordan	0.00	25,742.84	25,742.84

Donor	Prior Year(s)	2017	Cumulative
Mexico	75,177.71	10.99	75,188.70
Mongolia	698,012.68	410,120.15	1,108,132.83
Namibia	226,394.10	52,516.27	278,910.37
Nepal	0.00	11,377.69	11,377.69
Niger	146.92	4,491.12	4,638.04
Pakistan	21,074.41	36,274.27	57,348.68
Papua New Guinea	129,596.42	203,739.57	333,335.99
Paraguay	0.00	14.92	14.92
Peru	5,651.66	22,527.16	28,178.82
Philippines	76,127.77	11,851.44	87,979.21
Programme Division	177,392.80	184,969.52	362,362.32
Public Partnerships Division	0.00	5,259.36	5,259.36
Republic of Mozambique	113,468.50	183,530.11	296,998.61
South Africa	187,232.78	74,923.76	262,156.54
South Sudan	36,252.17	4,170.20	40,422.37
Sri Lanka	2,194.77	54,602.12	56,796.89
Sudan	0.00	4,693.52	4,693.52
Tajikistan	0.00	63,232.46	63,232.46
Togo	138,817.55	50,080.76	188,898.31
Ukraine	0.00	24,048.13	24,048.13
Viet Nam	287,661.21	10,034.22	297,695.43
WCARO, Senegal	373,016.98	13,906.03	386,923.01
Zambia	30,178.79	12,887.58	43,066.37
Zimbabwe	1,647,783.73	65.41	1,647,849.14
Total	12,541,928.51	5,772,140.54	18,314,069.05

SUMMARY

	Cumulative Expenditures	Cumulative Expenditures	Thematic Funds Available
Total	24,283,442.00	18,314,069.05	5,969,372.95

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