HEALTH

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NUTRITION

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2014
ANNUAL RESULTS REPORT
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***UNICEF**'s Strategic Plan 2014–2017 is designed to fulfil the organization's universal mandate of promoting the rights of every child and every woman, as put forth in the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women, in the current international context. At the core of the Strategic Plan, **UNICEF**'s equity strategy – emphasizing the most disadvantaged and excluded children and families – translates **UNICEF**'s commitment to children's rights into action. The first year of the Strategic Plan coincides with intensifying discussion in the international community on what the post-2015 development agenda will be. What follows is a report on what **UNICEF** set out to do in its Strategic Plan for 2014–2017 to advance the equity agenda through the organization's work on nutrition; what was achieved in 2014, in partnership with many diverse organizations and movements; and the impact of these accomplishments on the lives of children and families. This report is one of eight on the results of **UNICEF**'s efforts this past year, working in partnerships at the global, regional and country levels (one on each of the seven outcome areas of the Strategic Plan and one on humanitarian action). A results report on the **UNICEF** Gender Action Plan has also been prepared as an official **UNICEF** Executive Board document. The organization's work has increasingly produced results across the development-humanitarian continuum, and in 2014, **UNICEF** contributed to an unprecedented level of humanitarian assistance and emergency response. The report lays out what was learned through reflection and analyses, and what is planned for next year. It is an annex and is considered to be integral to the Executive Director's Annual Report 2014, **UNICEF**'s official accountability document for the past year.*

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Six-month-old Maniratou Mahamadou, held by her mother, Habsatou Salou, smiles after a nutrition screening at the Boukoki Integrated Health Centre in Niamey, the capital of the Niger. Timely growth monitoring ensures that signs of malnutrition or other ailments are detected early and appropriate treatment is provided. In February 2012, the Niger is one of eight countries in the Sahel region facing a nutrition crisis that now affects more than 10 million people. The crisis is the result of repeated drought-related food shortages, from which people have had insufficient time to recover before being affected once again.

CONTENTS

FIGURES AND TABLES

EXECUTIVE SUMMARY

Optimal nutrition lays the foundation for lifelong health, learning, and economic and social performance; it is one of the most important investments that can be made to realizing the rights of every child, especially the most disadvantaged. In a world where undernutrition contributes to almost half of child deaths globally and afflicts the poorest and most vulnerable children and communities,[1] UNICEF's rights-based approach to maternal, infant and child nutrition is crucial to tackling this inequity. In 2014, UNICEF's Nutrition Sector continued to be a leader in the scale-up of high-impact nutrition interventions, supporting countries in ensuring the equitable improvement of maternal, infant and child nutrition, with particular focus on the critical 1,000-day window covering a woman's pregnancy through the first two years of a child's life.

UNICEF supports nutrition programmes in more than 90 countries. While the global rate of undernutrition remains high, UNICEF's efforts to support countries are working. To illustrate, in 2013 75 countries were providing services to treat severe acute malnutrition (SAM) with UNICEF support, and globally, 2.91 million children were treated for the condition out of an estimated 17 million with SAM. About 2.9 million children were reached with micronutrient powders. Globally, 75 per cent of households were using adequately iodized salt. Vitamin A supplementation (VAS) remains a successful intervention in high-mortality settings; an estimated 65 per cent of children aged 6–59 months received the recommended two annual VAS doses in the 82 countries prioritized for national vitamin A supplementation programmes. Child malnutrition is best addressed through a holistic, life-cycle approach, ensuring that all children are born healthy and are properly cared for in their earliest years. With stunting, or low height to age, now being recognized as a key indicator of undernutrition, and with better understanding of the critical 1,000-day window for action, UNICEF and its global partners have been better able to target interventions in a time-sensitive manner to the most vulnerable women and children.

In the first year of UNICEF's 2014–2017 Strategic Plan, the Nutrition Sector met most of its expected results under **Outcome 4 – the improved and equitable use of nutrition support and improved nutrition and care practices.** These results are organized according to five programme areas: 1) general nutrition; 2) infant and young child feeding; 3) micronutrients; 4) nutrition in emergencies and the management of SAM; and 5) nutrition and HIV.

In the programme area of **general nutrition**, UNICEF finalized an internal guidance document in 2014 on scaling up nutrition programming for mothers and their children, detailing six operational approaches for more robust results-based nutrition programming. The purpose is to improve programme quality with a renewed focus on equity. As a key partner in the Scaling Up Nutrition (SUN) movement, the foremost driving force in global nutrition today, UNICEF continued to support nationally driven processes for nutrition programming. UNICEF substantially contributed to the first-ever Global Nutrition Report, which provides a comprehensive analysis of the state of the world's nutrition. Aligned with efforts to strengthen data collection and supply management, as well as better collate country-level programme information, UNICEF continued to improve its NutriDash platform – a web-based data collection tool which supports planning, including supply forecasting, and programme management for key nutrition programme areas – and published a report on the results of the pilot year. During the reporting period, UNICEF also supported 13 high-burden countries to develop, implement and monitor comprehensive equitable national nutrition plans.

In the programme area of **infant and young child feeding (IYCF)**, UNICEF and its partners finalized a breastfeeding advocacy strategy to foster leadership and alliances and effectively integrate and communicate breastfeeding messages, mobilize resources and promote accountability. The strategy also helps build knowledge and evidence to enhance breastfeeding policies and programmes. The IYCF programme also published a number of advocacy documents for policymakers and stakeholders, and produced joint UNICEF-World Health Organization (WHO)-Emergency Nutrition Network (ENN) guidance on IYCF in the context of

the Ebola crisis. UNICEF's joint IYCF course with Cornell University saw a surge in enrolment during the reporting period, and has now been accessed by more than 8,260 professionals in 170 countries. Given that globally, less than 40 per cent of children under 6 months are exclusively breastfed, UNICEF also maintained its focus on institutionalizing capacity development of health and community workers in the provision of infant IYCF counselling and support. For example, 85 per cent of countries (105 of 123 responding countries) report to have the capacity to provide IYCF counselling services to communities.[2] In addition, with UNICEF support, a number of countries are now pursuing concrete actions to improve breastfeeding and complementary feeding through a mix of interventions including social and behavioural change communication approaches, individual or group counselling, mother support groups and media campaigns. In 2014, UNICEF continued to support countries in adopting national legislation reflecting the International Code of Marketing of Breast-milk Substitutes and monitoring compliance. In 2014, 59 per cent of countries (73 of 123) reported having legislation or regulation on the Code, with a designated monitoring body.

In the **micronutrients** programme area, UNICEF helped improve policies and programmes to address micronutrient deficiencies at a large scale. As a result of this support, 82 countries now have legislation to mandate fortification of at least one industrially milled cereal grain. UNICEF also supported countries to improve policies to prevent anaemia. In 2014, 60 per cent of countries (74 out of 123) had a current national policy or plan to address anaemia in women of reproductive age. Over the reporting period, UNICEF country offices continued to build momentum for the scale-up of micronutrient powder interventions through programmes implemented in 43 countries. In 2014, UNICEF also continued its support for VAS via semi-annual outreach events such as Child Health Days and immunization campaigns. The most recent national coverage figures published by UNICEF in 2014 indicate that 69 per cent of children living in areas where vitamin A deficiency is a public health problem received the recommended two annual VAS dosages, with even higher coverage (81 per cent) in least developed countries.

In the programme area of **nutrition in emergencies and the management of severe acute malnutrition**, UNICEF continued to support countries through the provision of technical support and supplies. In order to address the needs of children under 5 with SAM in both emergency and non-emergency settings, with their marked increase in mortality risk, UNICEF continued to work closely with governments and partners to integrate SAM treatment into health systems and to strengthen government capacity to scale up and manage SAM treatment through leading policy change, providing technical support, and acting as the major provider of therapeutic foods. In humanitarian contexts in 2014, 2.29 million from a target of 2.75 million – or more than 83 per cent of targeted children – were admitted for treatment of SAM.

UNICEF continued to contribute to efforts to safeguard the nutritional status of children in emergencies in 2014, including via its response to concurrent large-scale Level 3 emergencies, including the Ebola crisis. Emergency response included providing in-country and remote technical support, identifying and deploying human resources and supplies, conducting assessments, undertaking advocacy and addressing guidance gaps. In 2014, UNICEF deployed an additional 58 individuals (including staff drawn from within the organization and externally) to support nutrition programmes in emergencies, and another 22 were deployed to support cluster coordination. One of the programme's key contributions in the Ebola response was in developing and disseminating interagency guidance on infant feeding and the treatment of SAM in the context of Ebola, as well as and nutritional support to Ebola patients. In response to the Ebola emergency, UNICEF, in collaboration with the World Food Programme (WFP), reached more than 600,000 people with nutrition services in hard-to-reach locations.

In the programme area of **Nutrition and HIV**, UNICEF developed a tool for determining the HIV status of children with SAM in emergencies, and partnered with WHO to revise HIV and infant feeding guidelines, bringing them in line with recent scientific evidence. At the country level, a UNICEF-led HIV and nutrition project in three countries showed that it is programmatically feasible to provide antiretroviral drugs to at least 70 per cent of the HIV-exposed breastfed infants, and to increase the proportion of children in SAM treatment tested for HIV within a few years, thus improving recovery rates and reducing mortality. This area of work needs to be further developed and supported by resources.

The year 2014 was particularly crucial for nutrition as development partners and governments worked to accelerate progress towards the Millennium Development Goals, and UNICEF began the first

year of transition to its Strategic Plan 2014–2017 which focuses on contributing to Millennium Development Goals 1, 4, 5, and 6. The year was also a turning point in the global nutrition landscape. Global consensus on key issues such as stunting, and the growing momentum for nutrition stimulated by the SUN movement and other partnerships has culminated in a global setting that is ripe for change and real progress in 2015 and beyond. In particular, the post-2015 sustainable development goals (SDGs) will be an opportunity to leverage this global attention to create better public support and knowledge, enhance national plans and policies, and receive diverse funds and resources in order to address nutritional issues that are captured in the draft SDGs, particularly Goal 2 to "end hunger, achieve food security and improved nutrition and promote sustainable agriculture." The evidence for investing in nutrition is unequivocal – what is needed is political commitment, resources and strengthened capacity to support national efforts to scale up nutrition.

Gaps in nutrition data and context-specific knowledge hamper evidence-based decision-making, especially at subnational levels. Although UNICEF, with its partners, has made significant strides to improve the availability and quality of nutrition data and strengthen nutrition information systems, more investment is needed. Improving use of data to inform decision-making, especially to inform programme planning and management, is critical for continuously improving the quality of our programming and maintaining our equity focus. Also, developing the systems to capture, synthesize and analyse programme knowledge and share best practices will help countries to achieve results more efficiently.

In addition, significant capacity gaps extend across the varied platforms used to deliver high-impact nutrition interventions, in both humanitarian and development contexts. More work is needed to develop national capacities for scaling up nutrition, and the proper guidance, tools and resources are necessary to accomplish this.

Moving forward, UNICEF continues to take measures to make the organization's work in nutrition more strategic, responsive and contextually relevant, while also being efficient and effective. Our strategic intent in nutrition, together with the priorities, is outlined in our new guidance on scaling up nutrition programming. This systematic approach will help to address challenges and constraints and improve programme quality across the regions and countries where we work.

In 2014, UNICEF spent US$484 million on nutrition; about half of nutrition expenditures (US$245 million) came from emergency funds, with US$173 million coming from other resources and US$65 million from regular resources. In terms of thematic contributions to the Strategic Plan outcomes and cross-cutting areas, of the US$341 million received in 2014, 1 per cent – or US$5million – was allocated to nutrition. Thematic funds are critical to the success of UNICEF's work in nutrition programming. With their flexibility, they offer the opportunity to strategically and more sustainably contribute to improving maternal and child nutrition. UNICEF wishes to acknowledge all government donors and National Committees that contributed to the work of the nutrition programme. UNICEF looks forward to new, and renewed support from donors to the nutrition sector. Nutrition is one of the most beneficial investments to improve child welfare and is critical to protecting and promoting child rights.

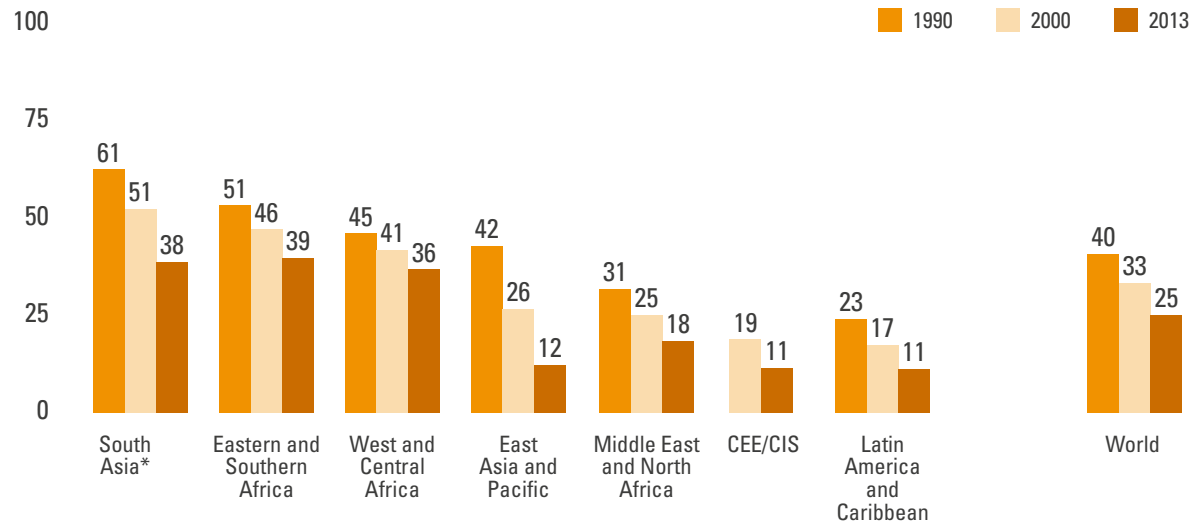
STRATEGIC CONTEXT

In 2014, the face of childhood malnutrition continued to change, with many countries facing complex, overlapping and interconnected nutrition challenges. In some cases, this means a triple burden of malnutrition – that is, the coexistence of stunting and wasting, micronutrient deficiencies, and overweight and obesity. There is also greater understanding of the short- and long-term consequences of undernutrition in all its forms, as well as greater understanding of the linkages between different forms of undernutrition – for example, the linkages between wasting and stunting and the increased mortality risk of manifesting both forms at the same time – which underscore the need for a comprehensive response to nutrition issues.[3,4] At the same time, global pressures including climate change, transitioning diets, population growth, urbanization, communicable and non-communicable disease threats and continuing poverty, as well as ongoing humanitarian crises, mean that good nutrition, particularly in infancy, is more important than ever.

Chronic malnutrition leads to stunting – an irreversible condition that literally stunts the physical and cognitive growth of children. The consequences of stunting cast a long shadow across the lifespan, affecting everything from school performance to future earnings. Globally, 161 million children under 5 are stunted.[5] About half of all stunted children live in Asia and more than one third live in Africa. Stunted growth remains the highest in the poorest households, thus becoming a key marker of poverty and inequality, hampering both the child's right to development and the development potential of nations. The past few years have seen significant progress in reducing global rates of stunting: between 2000 and 2013, stunting prevalence declined from one third to one quarter in children under 5 worldwide (*see Figure 1*). Despite this important progress, however, there is still a long way to go to reach the millions of stunted and wasted children globally. Addressing stunting and other forms of undernutrition is critical to achieving UNICEF's strategic goals and essential to protecting children's rights to survival and development.

FIGURE 1

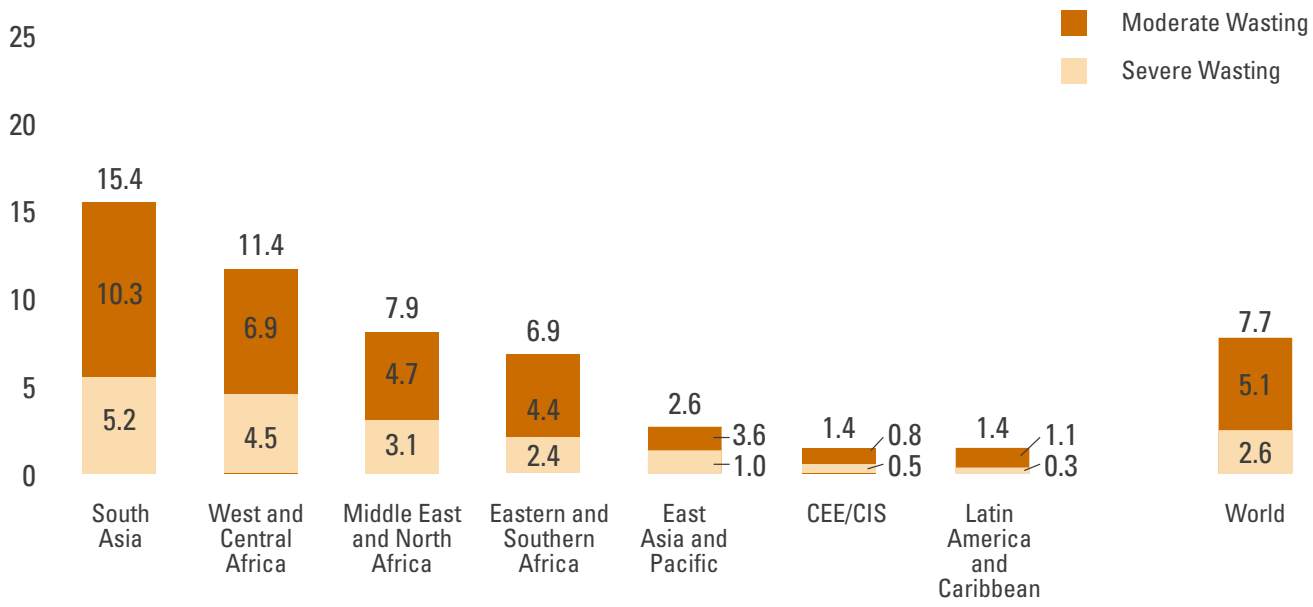
PERCENTAGE OF CHILDREN UNDER 5 WHO ARE STUNTED, BY REGION, 1990 TO 2013



Source: UNICEF/WHO/World Bank Joint Child Malnutrition Estimates, 2014.

FIGURE 2

PERCENTAGE OF CHILDREN UNDER 5 WHO ARE WASTED AND SEVERELY WASTED, BY REGION



Source: UNICEF/WHO/World Bank Joint Child Malnutrition Estimates, 2014.

The global situation with respect to wasting,[6] or low weight to height, is also critical and poses an immediate threat to survival. Globally, in 2013, 51 million children under 5 were wasted and 17 million were severely wasted (*see Figure 2*). This translates into a prevalence of almost 8 per cent and just less than 3 per cent, respectively. Approximately two thirds of all wasted children live in Asia and almost one third live in Africa, with similar proportions for severely wasted children.[7] Children with severe wasting – or SAM – have a risk of death nine times higher than that of children without SAM. Currently 7.8 per cent of deaths of children under age 5 are attributable to severe wasting.[8]

Despite these dire figures, progress is being made through proven interventions. Some of these include improving women's nutrition before, during and after pregnancy; promoting and supporting early, exclusive breastfeeding and continued breastfeeding to age 2 and beyond; facilitating timely, safe, appropriate and high-quality complementary food; and providing appropriate micronutrient interventions.

A MOMENT OF GLOBAL CONSENSUS AND CHANGE

The global nutrition landscape has changed dramatically in the past few years, with world leaders reaching consensus on some of the most pressing issues in nutrition science and policy. First, there is now global recognition of stunting as a key indicator of nutrition status, and in 2012 the World Health Assembly (WHA), WHO's governing body, endorsed a 40 per cent reduction in the number of stunted children as a global nutrition target for 2025.

Second, the evidence on the importance of the first 1,000 days is now irrefutable.[9] The greatest nutritional gains can be achieved in this period from pregnancy to the child's second birthday. At the same time, nutrient deficiencies and critical losses during this key period of growth may never be fully regained.

Third, evidence on the importance of the first 1,000 days is now guiding the delivery of time-sensitive interventions to address undernutrition

and micronutrient deficiencies during this critical period. This has involved sophisticated estimates of the cost and cost-benefit of implementing these interventions at scale. Gender-sensitive appro aches to programming are crucial to ensuring that the nutritional needs of women of reproductive age are privileged during this optimal time for growth and development.

Lastly, there is now greater consensus on the need for multi-sectoral approaches, and actions that are both nutrition specific (i.e., address the immediate determinants of nutrition status, such as inadequate diet) and nutrition-sensitive (i.e., address the underlying deter¬minants of nutrition status, such as food security and health access), while recognizing that nutrition-specific interventions will have the most significant impact. Nutrition cannot be addressed in a vacuum – it must be integrated within broader policies and frameworks on agriculture; social protection; education; health; and water, sanitation and hygiene (WASH).

More than ever, investing in nutrition is recognized as a key development priority benefiting global welfare. The Group of 8 of the world's wealthiest countries has put nutrition high on its development agenda, and the United Nations Secretary-General's Zero Hunger Challenge includes the elimination of stunting as a goal. The WHA committed to six global nutrition targets that, by 2025, would result in reduced stunting, wasting, low birthweight and anaemia (in women of reproductive age), increased rates of exclusive breastfeeding and no increase in childhood overweight. Nutrition improvements are inherently sustaining throughout the life cycle and across generations, and they contribute directly to the achievement of the draft SDGs. Improving child nutrition brings sustainable dividends to other sectors: well-nourished children are healthier, more resistant to disease, more attentive and perform better in school. Investment must start early in life to realize these dividends. Improving maternal and child nutrition gives children the best possible start in life, enabling them to reach their full potential.[10]

Nutrition is fundamental to UNICEF's post-2015 SDG priorities of ending poverty, ending preventable child deaths, improving the lives of adolescents, responding to humanitarian crises and building resilience. To give just one example: breastfeeding prevents death, childhood illness and non-communicable diseases, while supporting brain development and protecting maternal health. It is also environmentally sustainable and mitigates inequities by reaching even those with limited access to health services.[11]

Investing in nutrition ensures that the world's children can grow and thrive – and is also good value for money. The economic benefit-cost ratios of investing in interventions to reduce child stunting, for example, are highly competitive with other public investments.[12] As a further example, food fortification, a market food-based approach, is extremely cost-effective in addressing micronutrient deficiencies (US$0.05 – US$0.12 per person, per year[13]) and provides an opportunity to improve the lives of millions of people in a short period of time. According to the Copenhagen Consensus (2008), micronutrient fortification was one of the highest-return investment opportunities in the world, with estimated cost-benefit ratios of up to 39:1.[14] Put simply, nutrient investments make good economic sense and the returns for countries are high.[15]

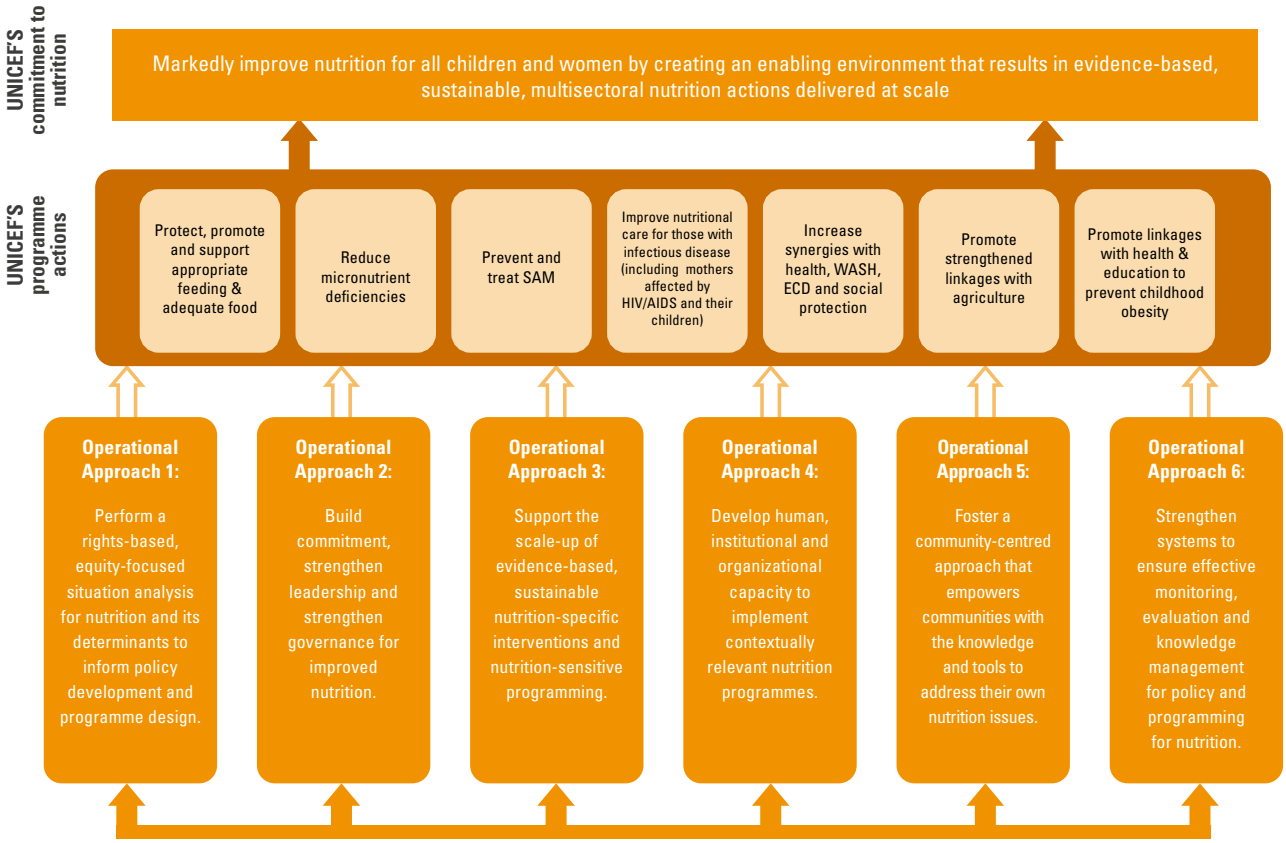
TOWARDS AN ENABLING ENVIRONMET FOR NUTRITION

In 2014, UNICEF and its partners worked to strengthen the global enabling environment for nutrition. This included advocating for the adoption of adequate policies and legislation and strengthening the political will needed for action – for example, advocating for the inclusion of language derived from the WHA global nutrition targets in the draft SDGs. The SUN movement, with its goal of translating country-led commitment for nutrition into results, is a key driver of the global enabling environment. It dominates global interest in nutrition – an interest that has increased tremendously in the five years since its inception – and mobilizes support for nationally driven processes to reduce stunting and other forms of malnutrition. UNICEF is a very active partner in SUN at global and national levels. In 2014, 13 new countries joined the SUN movement, bringing the total membership to 54 countries – a further step towards strengthening collective efforts to end malnutrition.[16]

The global context in 2014 was also shaped by the Second International Conference on Nutrition, hosted by the Food and Agriculture Organization of the United Nations (FAO) and WHO. Held at the end of 2014, the conference influenced global planning and strategizing about nutrition and highlighted the importance of strengthening

FIGURE 3

UNICEF'S OPERATIONAL APPROACHES TO IMPROVING NUTRITION PROGRAMMING FOR MOTHERS AND CHILDREN



Notes: Orange arrows illustrate that the operational approaches are interrelated.

the enabling environment. More than 2,200 participants attended the conference, including representatives from some 170 governments, 150 representatives from civil society and nearly 100 members of the business community. Participating governments endorsed two main outcome documents – the Rome Declaration on Nutrition and the Framework for Action[17] – committing to establishing national policies for eradicating malnutrition and transforming food systems to ensure that nutritious diets are available to all. In particular, the Framework for Action proposed a series of voluntary policy recommendations and strategies for use by governments, as appropriate.

Importantly, in 2014, UNICEF finalized its strategic guidance document, 'UNICEF's Approach to Scaling Up Nutrition Programming for Mothers and their Children'. The guidance supports country offices to systematically improve programme quality and operationalize the Strategic Plan goals in nutrition. It also supports country-level efforts in the design, implementation, monitoring and evaluation of nutrition, and outlines how UNICEF can engage with partners to achieve results. Importantly, for the first time, the issue of overweight and obesity is also addressed.

The global momentum for scaling up nutrition cannot be realized without investments in nutrition information systems to support programme implementation and monitor progress. The nationally representative Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS) led by UNICEF have helped build a growing body of information on the nutritional status of people in many low- and middle-income countries. This includes data related to acute malnutrition, IYCF, micronutrients and consumption of adequately iodized salt. Additionally, limited data on certain nutrition interventions in some countries are collected through initiatives such as the Global database on the Implementation of Nutrition

Action managed by WHO. Outside of the above initiatives, however, quality, routine data on the coverage and progress of programmes for programme improvement are not always systematically and holistically captured and reported at the country, regional and global levels. Recognizing the challenges countries face in collecting good nutrition data, UNICEF launched the NutriDash platform in 2013, with the aim of strengthening nutrition information systems, collating country-level programme and supply output. This innovation was supported by UNICEF country offices and several partners. Using NutriDash's web-based platform, programme data (mainly input and output indicators) for four programme areas (management of severe acute malnutrition, infant and young child feeding; home fortification with micronutrient powders and salt iodization) were collated and submitted. Following quality control, data can be analysed at country, regional and global levels to inform programme management, particularly planning and supply forecasting. As several indicators are aligned with Strategic Plan objectives, data from the pilot year 2013–2014 are featured throughout this report.

UNICEF AS A KEY PARTNER FOR CHANGE

Over the past few decades, UNICEF has gained considerable experience in nutrition programming, in both humanitarian and development contexts. As detailed in the 2013 flagship report **Improving Child Nutrition: The Achievable Imperative for Global Progress**,[18] UNICEF's Nutrition Sector has demonstrated success, and at scale. Efforts to scale up nutrition programmes are working, benefiting women and children and their communities in many countries. Knowledge generated through programming is being adapted and applied to improve nutrition programming. In addition, a meta-analysis of UNICEF's nutrition programme evaluations was published in 2014, the results of which have been integrated, shared and used to inform current programme objectives.[19]

UNICEF takes a holistic approach to nutrition programming, recognizing the cross-cutting nature of key results areas and privileging strategies to address them that are both nutrition-specific and nutrition-sensitive. For UNICEF, addressing the global burden of malnutrition and achieving the Strategic Plan outcome of "**improved and equitable use of nutritional support and improved nutrition and care practices**" requires action at global, regional and community levels. This involves integrating work across different areas in nutrition and other sectors, taking a life cycle approach that extends from programmes to policy level, from prevention to treatment, from development to humanitarian situations. This past year marks the first time that nutrition is being reported as a separate area in the Strategic Plan – a reflection of the global urgency to address malnutrition, its fundamental importance for children and nations, and the renewed momentum to leverage political support and funding for this objective. At the most basic level, it is also a global recognition that good nutrition lays the foundation for realizing all rights of the child.

Underpinning all work towards Programme Outcome 4 is a strong equity focus, ensuring the most marginalized and disadvantaged groups are reached, including populations with disabilities, HIV, adolescents and those suffering from gender discrimination. UNICEF also employs a Monitoring Results for Equity System (MoRES) framework in the Nutrition Sector, reaffirming the organization's commitment to promoting the use of data and evidence to enhance programming with an equity lens.

UNICEF's comparative advantage in nutrition is defined by several factors: large country presence (UNICEF supports nutrition programmes in more than 90 countries), strong programming and technical capacity, and a long-standing experience in the implementation of nutrition programmes. In addition, UNICEF invests in key global and national partnerships to harmonize strategic, policy and programmatic efforts around nutrition; and is a leading partner in global networks and initiatives for nutrition. Furthermore, UNICEF takes a leading role in the SUN movement, the Standing Committee on Nutrition, the Renewed Efforts Against Child Hunger (REACH) partnership[20] and several micronutrient networks, and is the cluster lead for Nutrition in Emergencies. UNICEF has Board presence on the Micronutrient Initiative (MI), is on the Partnership Council of the Global Alliance for Improved Nutrition (GAIN) and works closely with partners such as Save the Children, Helen Keller International (HKI) and Action Contre la Faim (ACF). In addition, UNICEF has strategic partnerships with other United Nations agencies as well as with the private sector.

PLANNING AND RESULTS OUTLINED BY PROGRAMME AREA[21]

In order to achieve results, UNICEF's nutrition interventions focus primarily on the critical window of the first 1,000 days, from pregnancy to a child's second birthday, when the greatest nutritional gains can be achieved. At the end of the first year of UNICEF's Strategic Plan 2014–2017, UNICEF has already seen significant progress in achieving the nutrition outcome regarding **the improved and equitable use of nutritional support and improved nutrition and care practices**. Through the strategies of service delivery, evidence generation, policy dialogue, advocacy, partnerships, cross-sectoral linkages and capacity building, among others, UNICEF is stimulating real change in the nutrition settings of many countries.

Drawing on UNICEF's Theory of Change,[22] this section describes the specific inputs and activities across different programming areas of nutrition, which are intended to achieve the outputs (listed under each programme area) that link to the overall nutrition outcome and feed into the overall intended impact of stunting reduction in children under 5 years, and anaemia reduction in women of reproductive age. Through the specific outputs described below, UNICEF aims to strengthen the supply and demand for nutrition support and improved nutrition and care practices. UNICEF intends to build an enabling environment that supports countries with a high burden of wasting, stunting and micronutrient deficiencies – as well as those with problems of overweight – to define, adopt, implement and scale up cost-effective and evidence-based policies and strategies to reduce malnutrition in both development and humanitarian situations.

PROGRAMME AREA 1 – GENERAL NUTRITION

One of the most important tasks of the general nutrition programme is to strengthen the global enabling environment, with the support of other partners, as well as to support development of effective and evidence-based overall national nutrition policy and programmes. UNICEF's leadership roles in the SUN movement and other global partnerships, discussed further below, are important strategies for ensuring that maternal, infant and child nutrition remain high on the global agenda.

At regional, country and subnational levels, and depending on country contexts, UNICEF adapts its approach to respond to national priorities. =At the global level, the organization's work in nutrition extends from policy to programming. In the area of policy, UNICEF works to create a more enabling environment from which to protect and promote nutrition. This includes advocating for nutrition to be on the national development agenda and adequately reflected in policy and legislative frameworks (including policies that protect and promote breastfeeding practices), and promoting social norms that encourage optimal nutrition. Institutional and budgetary commitment for nutrition creates opportunities to overcome previous obstacles to progress. For example, in many countries, inter-ministerial coordination and planning mechanisms are functioning, and inter-sectoral budgets are developed and increasingly funded. In the area of programming, UNICEF works with governments to implement comprehensive multisectoral nutrition programmes, working closely with communities.

The programme area of general nutrition is multisectoral, integrated with other programmes and supportive of national governments. The activities and results in this area are cross-cutting and support the work of the other four nutrition programme areas.

GENERAL NUTRITION – OUTPUT-LEVEL RESULTS

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

SUPPORT FOR SCALING UP NUTRITION

At the global level, one of UNICEF's most important achievements in nutrition in 2014 was the finalization of 'UNICEF's approach to scaling up nutrition programming for mothers and their children'. This guidance supports country-level efforts in the design, implementation, monitoring and evaluation of nutrition policy and programmes by stimulating policy dialogue and developing the capacities of national actors. UNICEF details six operational approaches that characterize more systematic, robust and results-based nutrition programming, with a renewed focus on equity. Based on a country's situational analysis, the guidance also includes a simplified schematic linking conditions to interventions for improving child and maternal nutrition. For example, the inadequate quality of complementary foods can be addressed via strategies of micronutrient supplementation, nutrition education counselling and fortified and supplemental/specialized foods (e.g., iodized salt). Alternatively, a high prevalence of anaemia among adolescent girls and women may be tackled via nutrition counselling and behaviour change communication, micronutrient supplementation and/or deworming in schools and during pregnancy.

The start of 2014 also marked the completion of the pilot year of UNICEF's NutriDash platform. With the aim of improving the systematic collection of nutrition data, NutriDash serves as an innovative platform for supporting country offices and improving programme management, including supply forecasting and resource mobilization. One of the innovations of NutriDash is to compile globally the number of people who receive nutrition services. The platform has also helped to provide a global overview on the strength of nutrition information systems. UNICEF published a report of the pilot year, capturing key output data at global and regional levels. One encouraging finding from the data is that nutrition is seen as a priority in 82 per cent of the national development strategies or plans of countries.[23] NutriDash data related to other programming areas will be discussed further in the respective programme areas of this report.

STRATEGIES, POLICIES AND PLANS

At regional and country level, UNICEF uses the strategies of evidence generation, policy dialogue, advocacy and capacity development to ensure that nutrition commitments are translated into the legislation and policies of national governments. A specific indicator selected to monitor this output on legislation is the number of countries that have a nutrition sector plan or policy developed or revised that includes a risk management strategy to address disaster/crisis risk. According to UNICEF's Country Office Annual Report Strategic Monitoring Questions (SMQ) data, 91 countries reported that a nutrition policy or plan was developed or revised with the support of UNICEF in the past five years. Of these, more than 61 per cent (56 of 91 responding countries) included a risk management strategy to address disaster/crisis risks. Nepal is one such example, where significant efforts have been made to integrate and institutionalize disaster risk reduction and climate change adaptation into sector programmes and plans in nutrition, as well as in education and WASH, in order to mitigate risk and reduce vulnerability in the most marginalized communities.

In 2014, UNICEF supported 13 countries with a high burden of stunting, wasting and micronutrient deficiencies to develop, implement and monitor comprehensive and equitable nutrition plans (based on a baseline of 2, towards a target of 18). In addition, UNICEF supported 11 high-burden countries to develop policies or strategies with comprehensive equitable undernutrition reduction strategies (from a baseline of 8 towards a target of 18).[24]

Result Assessment Monitoring (RAM) reported that UNICEF has also supported other country-level achievements in improving legislation. In 2014, UNICEF Rwanda worked with the Ministry of Health to review and update six outdated policies and strategies, including the National Food and Nutrition Policy and Strategy and others

related to nutrition, child health and development. In Papua New Guinea, UNICEF's continuous support of the development of a national nutrition policy and advocacy to strengthen interventions on SAM management helped to enhance national commitments to improving nutrition, and ended with a national nutrition policy being finalized in 2014. Valuable progress was also made in 2014 in the Democratic People's Republic of Korea, with UNICEF contributing to the upgrading of the National Nutrition Strategy and Action Plan 2014–18, and providing technical assistance to upgrade national guidelines for the community management of acute malnutrition, IYCF and micronutrient supplementation. In Chad, UNICEF contributed to the drafting of the National Food and Nutrition Policy covering the period of 2014–2025. The policy will enhance multi-sectoral coordination and allow the Government to effectively implement measures to prevent malnutrition. Additionally in 2014, UNICEF supported the Government of Bangladesh in developing the National Nutrition Policy and the National Strategy for Prevention and Control of Micronutrient Deficiency, both currently under approval process.

At the regional level, UNICEF's Eastern and Southern Africa Regional Office (ESARO) technically supported the development of the Africa Regional Nutrition Strategy 2015–2025 that will be adopted by the African Union. ESARO and the Western and Central Africa Office (WCARO) have given particular emphasis to strengthening human resource capacity in nutrition by strategically addressing needs identified in gap analyses. As a result, in more than eight countries, a nutrition curriculum assessment has been conducted to identify and address gaps. This will inform curricula development and the training of the next generation of nutrition cadre. Through its partnership with Cornell University, ESARO is continuing to implement and document the development of multi-sectoral nutrition systems – groundbreaking work, which will benefit the nutrition community not only on the African continent, but globally. Through the REACH partnership,[25] UNICEF also provided input to the European Union's planned programme to support the local production of complementary foods.

In 2014, UNICEF provided strategic support to country offices on general nutrition policy (for example, in Bangladesh, Burundi, the Democratic Republic of the Congo, India, Madagascar, Nigeria and Zambia) and on specific technical focus areas to strengthen capacity (including nutrition information in Malawi and mobile technologies in Burundi, the Democratic Republic of the Congo, Mauritania and the Niger).

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

STRENGTHENING MORES

In 2014, UNICEF continued to strengthen the equity, human rights and gender dimensions of its nutrition programme and to develop the capacities of governments and other stakeholders to integrate these factors into nutrition planning and intervention. At the global level, UNICEF developed further in-house capacity to support MoRES, training two additional staff members in this approach to better assist country offices in applying this methodology in nutrition programming and policy. In 2014, several UNICEF country offices, including Bangladesh, Burundi, Guatemala, Malawi and Zambia, were implementing or initiating the MoRES process for nutrition, with equity-focused nutrition data on outcomes and programmes including bottlenecks.[26]

GENDER AND HUMAN RIGHTS

Gender and human rights dimensions are cross-cutting in many of the results achieved in 2014. For example, a human rights-based approach to programming is underscored in the guidance on scaling up nutrition programming for mothers and their children (discussed above), with a focus on reaching the most disadvantaged populations. One of the indicators selected to measure the progress on this output is the number of countries with national management information systems that disaggregate data on nutrition. According to data compiled from a questionnaire to monitor the Strategic Plan, 92 countries (from a baseline of 85) have a national management information system that includes nutrition data, although it is not yet clear how often these data are disaggregated by gender.

A second indicator measures the number of countries that have undertaken a gender review of the nutrition policy/strategy in the current national development plan cycle with UNICEF support. While gender is mainstreamed into nutrition programmes, there is still progress to be made in incorporating gender equality in national policies. Only 18 per cent, or 22 of 123 countries,[27] have conducted a gender review of the nutrition policy/strategy in the current national plan cycle. One such country is Ghana, which conducted a gender assessment of the health and nutrition sector in 2014. This exercise revealed knowledge gaps on gender policies and resulted in a strengthened awareness of gender by key officials in the Ministry of Health, and the drafting of a strategic plan to guide gender mainstreaming in the sector.

Enchanced global and regional capacity to accelerate progress in child nutrition

SUN MOVEMENT

In 2014, UNICEF and other global nutrition partners continued to unite around the SUN movement. The movement is one of the most effective global partnerships for bringing about change on this output, bringing together national governments, donor countries, United Nations organizations, civil society and the private sector to support nationally driven processes to help scale up nutrition interventions. In 2014, 13 new members joined the SUN movement, bringing the total number of participating countries to 54.[28] UNICEF uses its position in the SUN UN Network to actively support progress of SUN globally and nationally.

At country level, governments are making progress on SUN with capacity development and technical expertise provided by UNICEF. Côte d'Ivoire joined the SUN movement in 2013 and a regional inter-agency mission was conducted to the country in early 2014, involving UNICEF, FAO, HKI, WHO, WFP and the United States Agency for International Development (USAID). This joint effort resulted in a road map for accelerating the scaling up of nutrition at the national level. A National Nutrition Council was established under the leadership of the Prime Minister, and UNICEF was designated as the convener of technical and financial partners for nutrition in 2014. UNICEF and partners contributed to the roll-out of the SUN road map, and UNICEF provided technical support to the National Nutrition Council for an extensive analysis of the nutrition situation, which provided a sound evidence base for the establishment of a National Nutrition Policy and cross-sectoral Nutrition Strategy. Similarly, in Myanmar, the advocacy efforts of UNICEF, WFP, FAO, ACF, HKI and Save the Children resulted in the national launch of the SUN movement and high-level political commitment for nutrition. Stakeholder network groups were established to support the scale-up of nutrition, with UNICEF convening the United Nations network group. Through the SUN country network, stakeholders reached consensus on a set of priority nutrition actions and interventions under SUN.

OTHER PARTNERSHIPS

UNICEF sees advocacy and partnerships as key strategies for accelerating progress on child nutrition. In 2014, UNICEF participated in major global advocacy events, including the Second International Conference on Nutrition (as discussed in Strategic Context); a joint briefing of the Committee on the Rights of the Child on the importance of IYCF and breastfeeding as major contributors to child rights; and the Inter-Parliamentarian Union Seminar for South and East Asia. UNICEF and the Inter-Parliamentary Union co-hosted this seminar in November 2014 in the Lao People's Democratic Republic to enhance understanding among parliamentarians of their roles and responsibilities in tackling stunting and promoting improved child nutrition. The meeting set forth concrete steps towards improved legislation and policy, budget allocation and expenditure, oversight and representation, and awareness raising.[29]

In 2014, UNICEF adopted the prevention of child stunting as its regional priority for South and East Asia, with the goal of reducing the number of stunted children in the region by 12 million over the next three years. To achieve this goal, the East Asia and the Pacific Regional Office (EAPRO) provided technical support to the South Asia Association for Regional Cooperation for the development of the Regional Nutrition Framework for Action, which was endorsed at the Heads of State Summit in November 2014. UNICEF also developed a regional strategy for the prevention of child stunting and convened the regional conference 'Stop Stunting: Improving Child Feeding,

Women's Nutrition and Household Sanitation in South Asia'. The conference provided an opportunity for policy dialogue, highlighted UNICEF's technical leadership and positioned UNICEF as a lead knowledge broker and convenor on maternal and child nutrition in the region. Following the conference, UNICEF set forth key actions to support the 'Stop Stunting' country teams for 2015–2017, including concrete joint actions by UNICEF Nutrition and WASH sections.

UNICEF also continues to be a main partner in the REACH initiative, which aims to improve intersectoral nutrition planning and programming in 13 countries.

A key indicator for success in this output is the number of global and regional nutrition initiatives in which UNICEF is the co-chair or provides coordination support. The nutrition sector made good progress on this indicator, assuming these roles in nine global initiatives.[30] Some important guidance documents have and will result from these partnerships, such as the Joint UN Guidance on Compendium of Nutrition Actions on multi-sectoral nutrition actions, coordinated by REACH and due to be completed in 2015.

EVIDENCE

Continued evidence generation is an important strategy to accelerate progress in child nutrition. The Strategic Plan indicator for this output is the number of peer-reviewed journal or research publications by UNICEF on nutrition in women and children. In 2014, UNICEF was the co-author of more than 45 international guidelines or papers in peer-reviewed journals on nutrition. Some examples include articles on nutrition and disabilities and measuring political commitment for nutrition; and on the Global Breastfeeding Advocacy Initiative, jointly led by UNICEF and WHO (Breastfeeding Medicine).[31] Some country-specific examples include nutrition transition in Albania (Albanian Medical Journal),[32] the performance of therapeutic feeding programmes to treat SAM in India (European Journal of Clinical Nutrition),[33] and Rwanda's evolving community health worker system (Human Resources for Health).[34]

One of the most significant contributions to the global evidence base was the release of the Global Nutrition Report, co-launched by UNICEF in December 2014. An impressive undertaking and key example of global partnership, the commissioning and development of the report was guided by a high-level stakeholder group as well as by members of government, donor organizations, civil society, multilateral organizations and the business sector. The report provides a comprehensive analysis of the state of the world's nutrition and strengthens the ability of policymakers, programme implementers, civil society advocates, investors, communities and families to monitor their society's progress in improving nutrition. UNICEF provided significant inputs into the report and participated in the stakeholder group and independent expert group.

REFLECTIONS AND LESSONS LEARNED

Over the past year, UNICEF has reaffirmed the importance of partnerships in achieving nutrition outcomes. However, partnership activities need to be continually prioritized, with time allocated for both global and regional partnerships and inter-sectoral collaboration.

There is a need for mechanisms to increase UNICEF's capacity to better manage country pro grammes (including quality assurance), deliver results (incorporating MoRES) and enhance UNICEF's accountability. The new guidance on scaling up nutrition programming for mothers and their children also incorporates several lessons learned, with operational guidance on how to improve programming.

In UNICEF, in the nutrition sector, the limited human resource capacity and challenge of filling key posts in a timely manner was identified as a key bottleneck. As a result, a P4/P5 talent pool was created that will more efficiently address human resource gaps. A human resource task team, consisting of global, regional and country office staff, has been created to strategize on recruitment and professional development.

In light of the need to increase resources to better deliver on the global and regional programmes and on providing direct country support, a section-wide fundraising strategy will be developed to fill resource gaps at global and regional level. Another priority in 2015 is the development of a global nutrition advocacy strategy to better guide UNICEF's efforts.

Based on the results of the pilot year of Nutri-Dash, UNICEF identified a need to further simplify

data entry, optimize outputs to meet country office needs, harmonize systems with ongoing data collection and improve linkages to supply and programme management. This is part of a broader goal to strengthen nutrition information systems to inform national nutrition plans and their implementation.

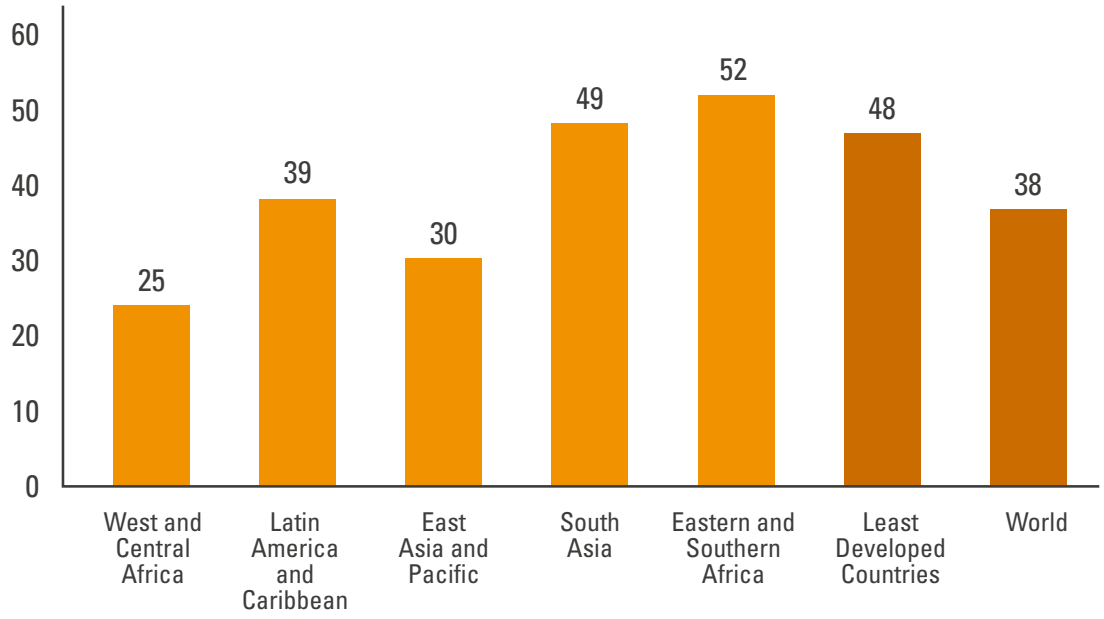
PROGRAMME AREA 2 – INFANT AND YOUNG CHILD FEEDING (IYCF)

Breastfeeding and complementary feeding are critical factors in child survival, growth and development. The protection, promotion and support of optimal breastfeeding practices constitute some of the most important preventive interventions for reducing child mortality and promoting brain development. The benefits of breastfeeding cannot be overstated: infants who are exclusively breastfed for the first six months of life (i.e., no additional foods, liquids or water) are less likely to die from diarrhoea and pneumonia, the two leading killers of children under age 5.[35] At the same time, suboptimal breastfeeding accounted for an estimated 800,000 deaths in children under age 5 in 2011, representing about 12 per cent of total child deaths in one year.[36] Rates of exclusive breastfeeding in children 0-5 months old are thus important indicators for measuring success in Outcome 4 – **the improved and equitable use of nutritional support and improved nutrition and care practices**. In 2014, 17 per cent (27 out of 98 countries with recent data on ICYF) showed an exclusive breastfeeding rate greater than or equal to 50 per cent and without any decline as of the past five years. Of those 27 countries, 13 had seen a significant increase in rates of exclusive breastfeeding (at least 10 percentage points).

In order to improve rates of exclusive breastfeeding, UNICEF supported countries in strengthening IYCF policies and legislation, promoting behavioural change communication strategies, building the capacities of governments and partners, and increasing the availability of counselling and mother support groups.

FIGURE 4

PERCENTAGE OF CHILDREN UNDER 6 MONTHS OF AGE WHO ARE EXCLUSIVELY BREASTFED, BY REGION



Source: UNICEF global databases, 2014, based on MICS, DHS and other nationally representative surveys

SCALING UP EXCLUSIVE BREASTFEEDING AND OTHER OPTIMAL IYCF PRACTICES IN BURKINA FASO

Burkina Faso has high prevalence of chronic and acute malnutrition, with a stunting rate of almost 33 per cent[38] (see Figures 5 and 6 below for trends in acute and chronic malnutrition over several years).

Suboptimal IYCF practices are important contributors to the high prevalence, with particular challenges including the lack of capacity of community health workers, the practice of giving water to infants before the age of 6 months, poor dietary diversity and low frequency of complementary feeding.[39]

In 2013, in an effort to reduce child stunting, UNICEF supported the Government in developing an ambitious 10-year plan titled 'Scaling up optimal infant and young child feeding practices, 2013–2025'. The overall goals of the plan are to 1) increase rates of exclusive breastfeeding in children under 6 months from 38 per cent (in 2012) to 80 per cent in 2025; and 2) increase the number of children age 6–23 months receiving the minimum acceptable diet, an indicator that combines information about breastfeeding or milk feeds, dietary diversity and frequency of meals, from 3.5 per cent (in 2012) to 30 per cent in 2025.The extremely low value of the indicator reflects the monotonous diet fed to infants and young children often due to a combination of factors, including lack of knowledge, lack of resources and food insecurity. Anecdotal evidence suggests that the situation in intervention areas is already improving.

UNICEF and the group of technical and financial partners in nutrition played a critical role in developing and implementing this scale-up plan. According to Burkina Faso's 2014 annual nutrition survey and national estimated results,[42] exclusive breastfeeding rates in infants under 6 months increased from 38.2 per cent in 2012 to 50.1 per cent in 2014; early initiation of breastfeeding remained at 42 per cent between 2010 and 2014; and the number of children age 6–23 months receiving the minimum acceptable diet increased from 3.2 per cent in 2012 to 11.4 per cent in 2014.

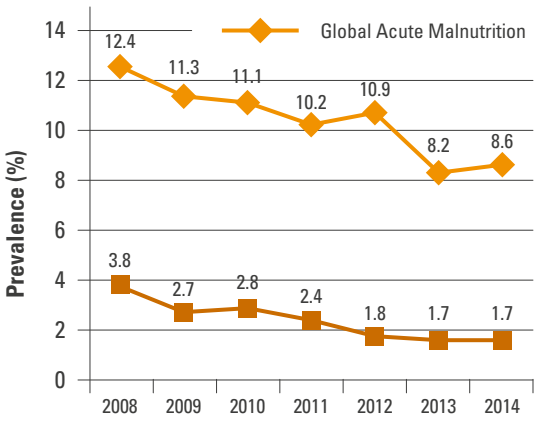
Progress on improving IYCF practices in the country was already beginning to take place and the scale-up plan further supported these efforts.

PREPARING THE GROUNDWORK FOR IMPROVED IYCF

Improvements in IYCF practices did not happen overnight; rather, they should be understood as part of a decade-long effort to strengthen nutrition frameworks and systematically scale up IYCF interventions in the country. For the past decade,

FIGURE 5

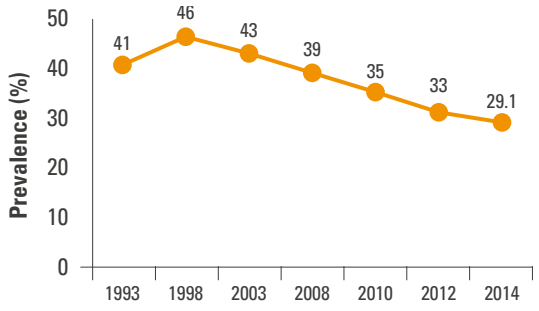
TRENDS IN GLOBAL AND SEVERE ACUTE MALNUTRITION IN BURKINA FASO



Sources:[40] Enquête nationale sur l'insécurité alimentaire et la malnutrition (ENIAM) 2008, SMART 2009, 2010, 2011, 2012, 2013, 2014.

FIGURE 6

TRENDS IN CHRONIC MALNUTRITION IN BURKINA FASO



Sources:[41] DHS 1993, 1998, 2003, 2010, ENIAM 2008, SMART 2009–2014.

Burkina Faso has worked to put in place nutrition policies, legislative frameworks and coordination mechanisms to foster an enabling environment for improving nutrition. The National Directorate of Nutrition was created in 2002, the National Nutrition Policy was adopted in 2007, and a National Consultative Council for Nutrition (a multi-sectoral coordination structure) was established in 2008. In addition, a monitoring and evaluation system was established in 2009, based on an annual national nutrition survey, and nutrition indicators are now included in the national health information system.

In a continued effort to strengthen the enabling environment, Burkina Faso joined the SUN movement in 2011, and a multi-sectoral road map was developed in 2012. In order to promote alignment and facilitate policy dialogue between partners, a Group of Technical and Financial Partners in Nutrition Security was set up in 2011, chaired by UNICEF. In 2012, UNICEF helped the Government introduce key IYCF indicators in the annual nutrition survey, using the SMART method, to encourage betternutrition data monitoring.

At the same time, media campaigns and communication for development activities carried out by non-governmental organizations (NGOs) and community-based organizations (CBOs) through the Ministry of Health's contractual approach in recent years have raised awareness and influenced behaviour change.[43]

These investments in nutrition over many years not only contributed directly to the improvements in IYCF practices but also fostered an ideal context from which to launch the 10-year plan to scale up optimal infant and young child nutrition. The total budget of the plan is estimated at US$83 million over a 10-year period. The unit cost is US$3 per beneficiary per year.

SCALING UP IYCF SUPPORT IN 2013–2014

In Burkina Faso, CBOs are key partners in health and nutrition service delivery, including the promotion of optimal IYCF practices. A 2011 coverage survey of IYCF services concluded that CBOs were reaching 70 per cent of children age 0–23 months[44] making it clear that these partnerships should be central and critical to the scale-up plan. In the first year of the plan, UNICEF supported the design of resources and tools for capacity development on community-based IYCF services, and these were tested in different regions of the country with the support of NGO partners. By the end of 2014, 4,788 community health workers had been trained in the new community-based IYCF interventions.

A mother-to-mother support group approach is being used as platform for community-based IYCF counselling, and to stimulate positive behaviour and social change. As part of the scale-up plan, each mother-to-mother support group includes 15 participants, supported by a community health worker, and provides an ideal entry point for multi-sectoral nutrition-sensitive interventions, such as homestead food production, home fortification, and optimal WASH practices promotion using a household model approach. In 2013 and 2014, a number of training, communication and monitoring tools were compiled into an integrated package of IYCF services through a life cycle approach. The package includes guidance on supporting early breastfeeding initiation and facilitating exclusive breastfeeding for six months. In total, 1,462 health workers were trained on using the package for health and nutrition service delivery.

The community component of the IYCF scale-up plan was tested in the Nord region with 60 per cent coverage of pregnant women and children age 0–23 months. In 2014, UNICEF supported the extension of the plan in the Plateau Central region with 80 per cent coverage. Through the 2013 and 2014 annual work plans, UNICEF invested US$3,380,076 in this project. Five other regions of Burkina Faso were reached through strategic partnerships with USAID's Resilience and Economic Growth in the Sahel - Enhanced Resilience Program and the Alive & Thrive Initiative.

LESSONS LEARNED

Burkina Faso's scale-up plan has been successful due to its participatory approach, planning and budgeting process (which has attracted predictable funding), and strong coordination among stakeholders. The nutrition investments made over a number of years have also culminated in an enabling environment for nutrition in general, which facilitates improvements in IYCF practices.

More specifically, an evaluation conducted in 2014 confirmed that mother-to-mother support groups were an ideal platform from which to stimulate behaviour change. In addition, 78 per cent of those surveyed felt that women who had been involved in mother-to-mother support groups during pregnancy would benefit from continuing involvement in a breastfeeding mother-to-mother support group after delivery. The results of the evaluation also noted the need to harness the support of community leaders to address cultural and social barriers to optimal IYCF practices. The low literacy level of some community leaders could make it difficult to use written communication tools.

The Burkina Faso experience with IYCF scale-up could provide a good practice model for other countries in the Sahel region facing high stunting rates.

MOVING FORWARD

The first two years of the project have provided a solid base from which to continue scale-up IYCF services. The next phase of the plan (2015–2022) will see progressive extension of services in four different clusters of regions that are prioritized according to poverty rate and stunting prevalence. The final phase (2023–2025) will involve consolidation of activities and documentation.

Over the next 10 years, more than 190,000 mother-to-mother groups will be established countrywide, and 36,000 community health workers will be trained and coached to support these groups. Ongoing dialogue with community leaders will help to address the cultural and social barriers for optimal IYCF practices. UNICEF Burkina Faso's 2015 work plan has a planned budget of US$2,124,894 to support the implementation of the IYCF scale-up plan. This represents an 83 per cent increase in the investment in IYCF from the 2011 annual budget of US$362,458.

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In 2014, evidence emerged that several countries, including Bangladesh, Burkina Faso, Burundi and the Niger, had seen rapid and sustained progress in improving levels of exclusive breastfeeding. In Burkina Faso, in particular, rates of exclusive breastfeeding jumped from just over 38 per cent in 2012 to more than 50 per cent in 2014. In Uganda, UNICEF's support in IYCF is contributing to a notable improvement in breastfeeding intervention areas: in the Karamoja region, more than 77 per cent of babies initiated on breast milk within the first hour of life and 81.5 per cent were exclusively breastfed. In the Plurinational State of Bolivia, recent national estimates show that the exclusive breastfeeding rate during the first six months of life increased to more than 90 per cent, and in Guinea-Bissau, the preliminary results of the MICS 2014 indicate that exclusive breastfeeding rates increased from 38 per cent in 2010 to over 52 per cent in 2014, in line with a significant reduction in the mortality rate of children under 5. Progress is also happening at the regional level: the average exclusive breastfeeding rate in the Eastern and Southern Africa region is now 51 per cent. In at least eight countries in this region, at least 50 per cent of infants 0–5 months old are exclusively breastfed.[37] UNICEF's strategic interventions to support this increase are discussed throughout this section of the report.

Improvement of complementary feeding, with age-specific counselling on IYCF, along with continued breastfeeding, are effective in improving child growth, and together with maternal nutrition interventions, contribute to reduced rates of stunting. These interventions are also important in mitigating future obesity risk. Improvements in complementary feeding are urgently needed in countries to reduce undernutrition. In Cambodia, UNICEF continued to support behaviour change communication to improve complementary feeding. As a result of UNICEF advocacy, a government long-term agreement to allocate free airtime for key nutrition messages is being discussed with national Cambodian television, and several behavourial change activities took place at the community level. In the Eastern and Southern Africa region, urgent attention is needed to monitor and improve the quantity and quality of complementary feeding. For example, only 4 per cent of children in Ethiopia are receiving the minimum acceptable diet. In the West and Central Africa region where data are available, only an estimated 10 per cent of children 6–24 months are receiving the minimum acceptable diet.

In accordance with the Global Strategy on Infant and Young Child Feeding,[45] UNICEF's goal in this programme area is to protect, promote and support optimal practices that improve maternal nutritional status, safeguard women's health and ensure good nutritional status for children. Optimal practices include initiating breastfeeding within one hour of birth, exclusive breastfeeding for the first 6 months of life and continued breastfeeding up to age 2 and beyond, together with safe, age-appropriate

feeding of solid, semi-solid and soft food starting at 6 months of age. A comprehensive approach to IYCF involves large-scale action at the national, health-system and community levels, including various cross-cutting strategies such as communication and context-specific actions on infant feeding in the context of emergencies and HIV.

IYCF – OUTPUT-LEVEL RESULTS

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

IYCF COUNSELLING AND SUPPORT

In 2014, UNICEF continued to focus on institutionalizing capacity development by supporting the adaptation and reproduction of training manuals, the training of facility-based and community-based health workers and supporting supervision and monitoring of services; and on the provision of infant and young child nutrition services, particularly counselling and support by health providers. Across communities and within families, the knowledge, behaviours, socio-cultural practices and social norms related to such services are addressed via comprehensive strategies for social and behaviour change communication. Community-based counselling and support is central to improving infant and young child nutrition, and it is particularly important in countries where the health system is weak. At present, 85 per cent of countries (105 of 123) say they have the capacity to provide IYCF counselling services to communities.[46] The Strategic Plan indicator for this output is the number of countries with capacity to provide IYCF counselling to at least 70 per cent of communities. Progress on this indicator in 2014 has been steady, with 20 countries having this capacity (from a baseline of 14 towards a target of 40).

At the global level, the WHO-UNICEF integrated counselling course on IYCF has been updated and will be disseminated in 2015. At the country level, UNICEF Ghana continued building capacity for the scale-up of community infant and young child feeding counselling in 2014. Since 2013, 1,475 health workers have been trained and are implementing the approach in 59 districts (61 per cent) in the five UNICEF focus regions. UNICEF supported the mentoring and supervision of 2,405 counsellors who had been trained so far by Ghana Health Services in 10 regions.[47] This past year in the Sudan, at least 350,000 mothers and caregivers received IYCF counselling support, an increase of 70,000 compared with 2013 and about 20 per cent of the total number of pregnant and lactating women in the targeted states.[48] In Bangladesh, national estimates show that more than 90 per cent of pregnant and breastfeeding women received nutrition counselling, with exclusive breastfeeding rates increasing from 49 per cent in 2012 to 81 per cent in 2014, and adequately diversified diet consumption rising from 48 per cent in 2013 to 68 per cent in 2014. Support from Alive & Thrive and UNICEF Bangladesh has been key to achieving these results.

UNICEF continuously updates its IYCF guidelines and tools to reflect recent country experiences and new knowledge. UNICEF's community IYCF counselling package, which was comprehensively revised in 2012, continued to be rolled out over the past year to strengthen countries' capacity to improve complementary feeding programming. The package is targeted for use in diverse country contexts, and guides local adaptation, design, planning and implementation of community-based IYCF counselling and support services at scale. According to NutriDash, approximately 60 responding countries are currently using some or all elements of the package in their programming. In Zambia, UNICEF used the package to support the capacity development of community volunteers and health workers in 10 districts to promote IYCF behaviour change and enable them to better support mothers and caregivers in the feeding and care of children. Additional modules are being added to the national IYCF training packages for health workers and community volunteers in 2015.

The results of the counselling package are also being evaluated to ensure they are appropriate and context-relevant. UNICEF has been involved in the design of the comprehensive evaluation of the community-based IYCF counselling package in Nigeria. Preparatory activities have begun and the baseline survey will be conducted in early 2015. The evaluation study will assess community workers' IYCF knowledge, counselling and communication skills, as well as the knowledge and attitudes of caregivers and other key community members.

Lastly, the evaluation will establish the impact of the package on uptake of the recommended IYCF practices.

CAPACITY BUILDING AND TRAINING

In 2014, UNICEF continued to develop capacity in countries via its e-learning course on IYCF, a partnership with Cornell University. UNICEF worked to update the course with two new video modules in 2014. Since its launch in 2012, the course has been accessed by more than 8,260 professionals in 170 countries. These results are impressive, and challenging to achieve in the context of a massive online open course. As Cornell University noted, "not only did enrolment surge, but the percentage of people who completed the 12-unit course far exceeded what is expected for a typical massive online open course. While completion rates for these courses usually average less than 15 per cent, the percentage of students who have finished the nutrition course to date is 32 per cent."[49] In 2014, the course continued to receive high ratings from participants, with 88 per cent of respondents rating the course as "very good" or "excellent" and 12 per cent rating it as "good."

In an example of partnership and triangular cooperation, UNICEF and Alive & Thrive organized an IYCF webinar for SUN focal points and members of their multi-stakeholder teams comprised of participants from governments, the United Nations and civil society in eight SUN countries: Bangladesh, Indonesia, Lao People's Democratic Republic, Myanmar, Nepal, Pakistan, Sri Lanka and Viet Nam. The webinar achieved its objective of sharing successful country experiences in mobilizing governments to promote, protect and support breastfeeding.

IYCF IN EMERGENCIES

In 2014, UNICEF provided technical support and guidance to countries on IYCF in emergencies, particularly with respect to the Ebola crisis, which required a significant redirection of time and resources and close collaboration with the regional office and the three affected country offices to provide support to the governments. This type of support was crucial given the fact that Ebola can be transmitted via breast milk, and all infant feeding practices require 'touch' contact and therefore, there is potential for the spread of disease. Overall, a key achievement of this work was the drafting of global guidance on IYCF in the context of Ebola,[50] coordinated by UNICEF in partnership with WHO, ENN and others. As a result of the guidance, ready-to-use infant formula (RUIF) was procured by country offices and its use closely monitored. Close collaboration with Health and Child Protection colleagues was also established in the course of the Ebola response. A multi-sectoral UNICEF mission to Liberia resulted in the Government's adoption of modified policies on nutrition, including IYCF practices, in the context of Ebola.

In Cuba, UNICEF developed, edited, printed and disseminated a practical guide to nutrition and food management for vulnerable groups in emergency situations. The Middle East and North Africa region also carried out an analysis of IYCF interventions in the Syrian crisis response, preparing a comprehensive set of training materials for capacity building in the region and an 'IYCF in emergencies' monitoring checklist to guide stakeholders involved in the ongoing response. In Indonesia, UNICEF acted to prevent and address uncontrolled donations and use of breast-milk substitutes by alerting the Ministry of Health, advocating with Provincial and District Health Offices, informing humanitarian actors and donors on the dangers of such use in emergencies and mobilizing NGOs to monitor actions on the ground. In 2014, UNICEF trained 80 humanitarian actors (government, United Nations and NGOs) in Indonesia on infant feeding in emergencies, with a specific focus on preventing and responding to uncontrolled distribution of breast-milk substitutes, and preparation of appropriate complementary foods for young children.

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

ADVOCACY

In 2014, UNICEF intensified its focus on advocacy as a strategy for building political accountability and strengthening the legal frameworks to promote and protect breastfeeding. In December 2014,

UNICEF, in partnership with WHO and others,[51] finalized and disseminated the Global Breastfeeding Advocacy strategy. The strategy reflects substantial inputs from a broad range of global nutrition partners and will be used as a framework to guide advocacy efforts around breastfeeding. The strategy articulates the collective vision, mission and strategic goals of the Global Breastfeeding Advocacy Initiative, funded by the Bill and Melinda Gates Foundation. Its strategic goals are: 1) foster leadership and alliances and effectively integrate and communicate breastfeeding messages; 2) mobilize resources and promote accountability; and 3) build knowledge and evidence to enhance breastfeeding policies, programmes, financing and communication. UNICEF will co-lead three working groups corresponding to the strategic goals of the breastfeeding advocacy strategy and will facilitate a work planning process to implement it in 2015–2017.

Partnerships and cross-sectoral linkages help UNICEF to strengthen its advocacy and capacity development work on breastfeeding and infant and young child nutrition. As part of the Bill and Melinda Gates Foundation partnership, UNICEF undertook joint Nutrition Sector and Health Sector scoping missions in Bangladesh, Ghana and Kenya to explore opportunities to support the governments in scaling up quality maternal and newborn health care, including breastfeeding. UNICEF met with Government policymakers, programme managers and partners to brief them on the partnership initiative and review country programmes and policies for maternal and newborn health, quality improvement and breastfeeding. It was also an opportunity to develop strategic alliances and to provide technical support to country teams for the development of country operational plans.

In 2014, UNICEF also published a number of advocacy documents targeting policymakers and stakeholders. For example, UNICEF produced technical briefs on the importance of nutrition and breastfeeding for attainment of the draft SDGs,[52] and contributed to WHO policy briefs on breastfeeding and wasting. UNICEF's communication and advocacy materials on breastfeeding and newborn health were endorsed by diverse partners. The Nutrition Sector also used the United Nations General Assembly as an opportunity for advocacy on breastfeeding, participating in a number of side events and strategized with partners on the inclusion of breastfeeding and other WHA nutrition targets in the draft SDGs.

A number of countries are implementing communication and advocacy strategies to better promote breastfeeding and other optimal IYCF practices. According to recent estimates, 58 per cent of countries (45 out of 77 reporting on this indicator via Nutridash) had a communication strategy for IYCF in place, either as a stand-alone strategy or integrated into a broader communication strategy.[53] World Breastfeeding Week in August 2014 provided an important opportunity for advocacy and communication at country level. With UNICEF and other partners, a number of countries, such as Guyana, Mongolia and Tajikistan, used mass media to broadcast key messages and engage with communities. Other countries commemorated the week with events, such as in Mexico, where UNICEF co-organized the second regional forum on breastfeeding, including a South-South exchange to the event facilitated by UNICEF colleagues in Brazil, Chile and Viet Nam. At the global level, a short publication on the critical importance of early initiation of breastfeeding for newborn survival and health was produced and endorsed jointly by nutrition and maternal and newborn health organizations, and was disseminated to all country offices to aid in advocacy efforts during World Breastfeeding Week.

POLICY AND LEGISLATIVE FRAMEWORKS

A number of countries are making progress in strengthening the legal frameworks to support optimal IYCF. In total, 87 per cent of countries (70 out of 80 reporting on this particular indicator via NutriDash) have some type of IYCF policy[54] in place. One of the most important ways that countries can strengthen legislation in this regard is by adopting the provisions of the International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions into national legislation. The Code aims to protect and promote breastfeeding by prohibiting all forms of promotion of breast-milk substitutes, including infant formula, bottles and teats. As of 2014, 59 per cent of countries (73 of 123, based on UNICEF country office annual reports) have legislation or regulation on the Code, with a designated body carrying out ongoing monitoring.[55] Due in part to UNICEF's advocacy efforts, Armenia adopted a national law on 'Breastfeeding promotion and regulation of infant food marketing' in 2014 to ensure comprehensive legal protection for breastfeeding and to

regulate the marketing practices of infant formula makers in the country. Also in 2014, UNICEF supported the Bangladesh Ministry of Health to develop rules and regulations to accompany the 2013 Breast-milk Substitute Law, thereby strengthening the scaling up of a national monitoring system for Code compliance. In Myanmar, following the endorsement of the national order on the marketing of formulated food for infants and young children in July 2014, UNICEF is supporting the Government in conceptualizing a system and identifying partnerships to monitor and enforce order compliance at all levels.[56] And in November 2014, as a result of advocacy efforts by UNICEF and Alive & Thrive, the Government of Viet Nam adopted a decree on marketing and use of nutritional products for young children such as feeding bottles, teats and pacifiers, extending the prohibition on promotion to all breast-milk substitutes for children up to the age of 24 months.

Other countries are studying the scope of existing Code violations in order to improve monitoring systems. For example, UNICEF, in collaboration with the Egyptian Lactation Consultant Association, completed a study on 'Compliance with the Code of Marketing of Breast-milk Substitutes in Egypt'. The study findings were presented to the Ministry of Health and Population and other related parties to advocate for implementation of the Code, including prohibitive legislations to combat Code violations. UNICEF has also been active in facilitating the cooperation between the Ministry of Health, the Albanian branch of the International Baby Food Action Network and the National Health Inspectorate in monitoring the implementation of national commitments to promote breastfeeding. A study launched in 2014 indicated that more than 95 per cent of the maternity facilities in Albania have been applying rooming-in and early initiation of breastfeeding. At the same time, there have been numerous violations of the existing 'Law for the Promotion and Protection of Breastfeeding' by infant formula producing and trading companies, and free samples of breast-milk substitutes continue to be distributed to mothers via different channels. Similarly, South Africa conducted a baseline study for understanding the status of violation of the Code in 2014, the results of which will inform the planning and implementation of a monitoring system to track violations.

Several countries are moving ahead with implementing the Code, with technical support from UNICEF – for example, Hong Kong (at the request of the China country office), the Lao People's Democratic Republic and Thailand. UNICEF continues to work with WHO and other partners on the development of a Network for Global Monitoring of the International Code of Marketing of Breast-milk Substitutes and Subsequent relevant WHA resolutions. A major barrier to Code implementation is the 'rearguard actions,' tactics of the breast-milk substitutes industry, which tries to incorrectly persuade governments that Code implementation will result in challenges before the World Trade Organization for breach of international trade and intellectual property agreements. There is no legal basis for such claims, but in order to alleviate concerns on the part of governments, UNICEF is working with legal experts to develop a brief that can be used by country offices to reassure counterparts as they move ahead on Code implementation.

Implementation and monitoring of the Code is important, but many countries also need other legislation to support optimal IYCF, such as adequate maternity leave and support for breastfeeding in the workplace. Only 38 per cent of SUN countries reported having adequate maternity protection (e.g., that which is in line with the International Labour Organization Maternity Protection Convention, 2000 no. 183) in 2013.[57] Some progress has been made in this regard, for example in Viet Nam, where maternity leave was extended to six months via the adoption of the labour code amendment. Similarly, in Myanmar, UNICEF supported the National Nutrition Council in advocacy and technical discussions with key parliamentarians and the Ministry of Labour, resulting in the extension of maternity leave in the public sector from 12 weeks to 6 months and the extension of maternity leave in the private sector from 12 weeks to 14 weeks. While 86 per cent of countries (69 out of 80 reporting) have maternity protection legislation in place, the duration and amount of paid maternity leave, availability of breastfeeding rooms in the workplace, provision for breastfeeding breaks and other enabling workplace conditions require greater attention.[58]

REFLECTIONS AND LESSONS LEARNED

At the global level, the IYCF programme identified a number of ways to improve its advocacy strategies, in particular as it moves forward with the Breastfeeding Advocacy Initiative. There is a need to clarify the audience and purpose for all advocacy products, refine work processes, and improve

knowledge management. Insufficient funds and response to emergencies were barriers to implementing all planned activities.

At the national level, progress is being made in a number of countries to improve rates of exclusive breastfeeding and bring national legislation in line with Code provisions. At the same time, many countries are struggling to address the social and cultural practices that pose barriers to optimal infant and young child nutrition. Social norms are often bottlenecks to influencing optimal IYCF practices. In 2015, Ethiopia will conduct operational research to identify major social and behavioural barriers, and the findings will be used to improve the design and delivery of IYCF messages. In South Sudan, UNICEF will work with the Ministry of Health on an assessment of current practices to inform a new evidence-based and contextually relevant plan to address barriers, including cultural norms. Supporting the integration of IYCF in the health system is also essential, as there are often missed opportunities to promote and support improved IYCF practices. Strengthening linkages with other sectors such as early childhood development, WASH and social inclusion is an area that requires further attention.

PROGRAMME AREA 3 – MICRONUTRIENTS

Globally, an estimated 2 billion people suffer from a deficiency in at least one micronutrient (i.e., vitamins or minerals).[59] The prevalence estimates, and overlap of different deficiencies, are highest among disadvantaged populations. Deficiencies of essential micronutrients are particularly common among women and children. To illustrate, vitamin A deficiency affects one out of every three children living in low-resource settings, thus affecting an estimated 190 million children around the world. Further, anaemia, often a result of iron deficiency, affects 29 per cent of non-pregnant women, 38 per cent of pregnant women and 43 per cent of children under 5.[60] Iodine deficiency, the result of deficiency in iodized salt, remains prevalent in 25 countries.[61] Deficiencies in other micronutrients such as B12, folate and zinc are also likely to be common among women and children, but the exact burden has to be better characterized.

Micronutrient deficiencies have considerable adverse effects at individual and societal levels. For example, the lack of iron or iodine can irreversibly impair child brain development, the lack of zinc can impair growth, and the lack of vitamin A can weaken immunity. Iron deficiency and anaemia increase the risk of adverse outcomes for mother and child, including the risk of maternal mortality, fetal death and low birthweight, while maternal folate deficiency increases the risk of birth defects of the brain, spine or spinal cord.

Owing to the high prevalence of micronutrient deficiencies and associated burden, UNICEF supports national programmes to improve access to vital micronutrients among women and children. To this end, UNICEF supports the following strategies at large scale: 1) supplementation (for example, VAS for children 6–59 months old); 2) food fortification (for example, iodization of salt, fortification of flour and oil); and 3) improved complementary food products (including micronutrient powders) to improve dietary quality. These strategies, together with prevention and treatment of infectious diseases to minimize micronutrient depletion, can mitigate micronutrient deficiencies among vulnerable groups.

As a reflection of its commitment to addressing micronutrient deficiencies, UNICEF has defined two outcome-level indicators in its Strategic Plan to monitor selected micronutrient interventions. First, UNICEF monitors the number of countries with at least 90 per cent of households consuming iodized salt. Second, UNICEF tracks the number of countries where at least 90 per cent of children aged 6–59 months are covered with the recommended two annual doses of vitamin A supplements. The most recent national coverage figures published by UNICEF in 2014 indicate that 69 per cent of children in low-resource settings received the recommended two annual VAS dosages and were thus fully covered against mortality related to vitamin A. Notably, VAS coverage in least developed countries (at 81 per cent) was higher than the global average.[62]

MICRONUTRIENTS PROGRAMME OUTPUT-LEVEL RESULTS

Increased national capacity to provide access to nutrition interventions

SCALING UP SUPPLY AND COVERAGE OF VITAMIN A

UNICEF supports 95 per cent of the world's vitamin A supplements for developing countries, with the bulk of the funding coming through the Micronutrient Initiative (MI).[63] Costing only two cents per capsule, this simple supplement can improve a child's chance of survival by 24 per cent. For nearly two decades, UNICEF has partnered with MI with the joint objective of supporting country-driven plans to increase and sustain high coverage of VAS (wherein MI provides in-kind assistance of vitamin A capsules). This includes a focus on improving inventory management and reducing wastage in the supply chain. As a reflection of UNICEF's commitment to the supply of vitamin A capsules, UNICEF defined a specific indicator on vitamin A capsule supply in the Strategic Plan 2014–2017.

With the support of the Government of Canada, MI and other donors, UNICEF is supporting national governments with the delivery of vitamin A supplements alongside other interventions. Experience shows that semi-annual outreach events such as Child Health Days are crucial opportunities to enhance coverage of vitamin A supplementation and other essential child survival interventions, particularly in harder-to-reach groups. At the same time, UNICEF is advocating for national governments to take on increased operational and fiscal responsibility for sustaining VAS coverage progress. For instance, UNICEF, alongside HKI and MI, supported the Government of Senegal to shift from campaigns towards routine delivery of services in districts with favourable performance indicators. In addition, UNICEF harnessed its role as the lead agency for the Every Woman Every Child initiative to successfully advocate for the Government of Senegal to include funding for vitamin A capsules and ready-to-use therapeutic foods (RUTF) in the list of 17 essential commodities for children, leading to an agreement between the Ministry of Health and the National Pharmacy for the management and distribution of vitamin A in the United Nations commodities framework – an important breakthrough.

Nevertheless, Child Health Days and integrated immunization campaigns have been the major delivery mechanism for VAS in 2014. Of note is that these delivery mechanisms achieve high coverage in settings plagued by fragility, weak health systems and high under-5 mortality rates. For instance, more than 90 per cent of children 6–59 months old were reached with VAS twice a year in Chad and the Democratic Republic of the Congo in 2014. However, the biannual delivery of VAS is also very successful in numerous other settings. For example, Benin achieved its vitamin A coverage targets for 2014, with greater than 90 per cent VAS coverage being sustained through its full integration with polio immunization events. As in other settings, UNICEF's role is to support the logistical planning, provide supplements and then assist in monitoring and evaluation. In the United Republic of Tanzania and numerous other countries, UNICEF plays vital roles in the procurement of supplies and in training, technical support and supportive supervision of the programme.

UNICEF and partners use immunization campaigns and other integrated platforms such as Child Health Days to reach children with vaccines, VAS, deworming medication and other high-impact interventions. Such integrated approaches are more efficient and may increase demand for interventions compared with stand-alone campaigns. In 2014, UNICEF supported countries to identify context-specific solutions to deliver VAS. Furthermore, UNICEF was able to support such supplementation even in highly challenging environments, such as during the humanitarian crisis in the Central African Republic. Aided by a grant from the Government of Canada, UNICEF works with 13 governments in sub-Saharan Africa to institutionalize VAS in government plans. Furthermore, UNICEF offices conducted bottleneck analyses to identify constraints at national and subnational levels, and developed key performance indicators related to stock-outs and supportive supervision. These activities were aligned with, and in support of, UNICEF's broader initiatives to improve equity, such as MoRES, and accelerate progress towards results for the most deprived children.

In 2014, several countries faced contextual barriers, such as the Ebola crisis, political unrest and insecurity, which threatened progress towards

vitamin A coverage. For example, just prior to the Ebola outbreak in Sierra Leone, the country had conducted one round of Maternal and Child Health Weeks in June 2014 (including VAS, deworming, insecticide-treated bed nets and behaviour change promotion as part of the integrated package) with very high coverage. Once the epidemic was under way, however, major activities, including the second round of Maternal and Child Health Weeks, had to be suspended and postponed to 2015.

HOME FORTIFICATION WITH MICRONUTRIENT POWDERS

Micronutrient powders (MNP) – single-dose packets of vitamins and minerals in powder form – are a novel approach to improving the dietary quality of complementary food. Given that a range of homemade foods can be fortified with MNP, their use is referred to as 'home fortification'. MNPs can easily be added to foods immediately before consumption, and thus do not require a change in preferred dietary practices.

As in previous years, UNICEF was one of the major supporters of home fortification programmes worldwide. UNICEF had previously implemented six landmark regional workshops to generate the required advocacy support and capacities among programme managers. As a sign of the success of these efforts, almost 3 million children were reached with MNP by 2014 through programmes implemented in 43 countries. This is significant given that, as recently as 2011, only 22 countries were implementing MNP programmes. UNICEF country offices are a major driver of these programmes at country levels and help create a favourable enabling environment (including adoption of relevant policies), develop demand and behaviour change strategies, and implement monitoring and evaluation systems to reach the target populations.

Kyrgyzstan is one example of successful MNP programming. With support from UNICEF, the Government of Kyrgyzstan is now able to reach 205,000 children through its national programme. A rigorous evaluation of this programme[64] previously showed reductions in child iron deficiency and anaemia. By addressing these conditions, the programme therefore helps in improving brain development, learning capacity and health status among Kyrgyz children. In addition to addressing iron deficiency and anaemia, carefully designed programmes can also help improve the quality of complementary feeding practices, which is an important determinant of child stunting. To illustrate, UNICEF's support to the Government of Madagascar has shown that in addition to addressing anaemia, social marketing[65] of MNP can strengthen communication around infant and young child feeding, thereby improving complementary feeding practices while protecting exclusive breastfeeding practices. After one year of implementing social marketing programmes in Madagascar, anaemia levels decreased 14 per cent; at the same time, dietary diversity increased from just under 11 per cent to more than 46 per cent. Exclusive breastfeeding in children under 6 months and continued breastfeeding up to age 2 remained unchanged, suggesting that the messaging on complementary feeding protected breastfeeding practices.[66]

In support of these national programmes, UNICEF headquarters co-chairs the global Home Fortification Technical Advisory Group (HF-TAG), a global network of stakeholders tasked with providing support to the implementation of effective home fortification programmes. With other HF-TAG members, UNICEF helped develop joint guidance on programme scale-up of home fortification with MNP in 2014. The document, titled 'Planning for Program Implementation of Home Fortification with Micronutrient Powders: A step-by-step manual', outlines key steps and considerations for the design, implementation and management of MNP programmes, based on a programme cycle model. UNICEF also leads a review of the current nutritional composition of MNP and the organization of webinars and communities of practice.[71] In 2014, the communities of practice and webinars had global reach with participation from 63 and 17 countries, respectively.

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

UNICEF and its partners advocate for improved legislation, build the capacities of national actors and improve the knowledge base required for action. In 2014, UNICEF engaged in global leadership and partnered with other organizations to contribute to this output, including MI, the Global Coalition

ACHIEVING RESULTS AT SCALE: IMPLEMENTING A NATIONAL ANAEMIA-CONTROL STRATEGY WITH MICRONUTRIENT POWDERS IN KYRGYZSTAN

Childhood iron deficiency and anaemia together represent an important public health problem in Kyrgyzstan. Anaemia has historically affected one out of every two children under the age of 3 in the country. In addition, iron deficiency, the most important contributing cause of anaemia, is related to irreversible cognitive damage and a diminished ability to fight infections.

Research studies and small-scale programmes suggest that the 'home fortification' of foods with MNPs is an effective anaemia control strategy. MNPs are single-dose sachets containing five micronutrients in a powdered form that can be easily sprinkled onto any food prepared in the household for the child. MNPs can reduce anaemia by 31 per cent and iron deficiency by 51 per cent on average.[67] WHO therefore recommends home fortification of foods with MNPs to improve iron status and reduce anaemia in young children.

With this research in mind, UNICEF and the United States Centers for Disease Control and Prevention (CDC) supported the Government of Kyrgyzstan in the design and implementation of a phased MNP programme aiming to reach national coverage within three years. The rationale for the programme was that it would create an enabling environment, generate adequate demand for the intervention, establish reliable supply systems, and implement a level of care to ensure proper use of the product. Coupled with rigorous monitoring and evaluation systems, UNICEF and partners estimated that the intervention could eventually reach national coverage, resulting in clear impacts for young children.

LAUNCH OF THE PILOT PROGRAMME

In 2009, a pilot programme was initially launched in the Talas province with the aim of generating further evidence for subsequent national programme scale-up within three years. This first phase aimed to establish a normative base from which UNICEF and partners could obtain further support from key stakeholders. In addition, it aimed to conduct formative research on IYCF practices and product acceptability, collect baseline nutrition information, develop monitoring guidelines, and create robust procurement and supply management systems.

The pilot programme implementation benefited from strong media support and communication activities by village health committee volunteers. The intervention was embedded within the larger IYCF programme and trained primary health-care providers (doctors, nurses and nurse practitioners) distributed the product free of charge to caregivers of all children 6–23 months old. Kyrgyzstan procures its MNP through UNICEF, but in order to enhance acceptance the product was given the local brand name 'Gulazyk', the Kyrgyz word for a dried meat product that is rich in nutrients and is eaten by warriors and travellers to give them strength and energy.

As part of the programme's internal monitoring system, health clinics keep patient registries that allow health-care providers to track children who stop using the powder, those who experience side effects, and those whose caregivers refuse to try the MNP. This monitoring was incorporated into broader national systems for the integrated management of childhood illnesses.

One year after the distribution of MNPs in Talas province, the results from a follow-up survey showed statistically significant declines in the prevalence of anaemia, iron deficiency and iron deficiency anaemia. Compared with the baseline survey conducted in 2008, the 2010 survey showed that, among all children 6–23 months of age, anaemia prevalence declined from 50.6 per cent to 43.8 per cent ($P=0.05$); total iron deficiency prevalence (either low ferritin or high serum transferrin receptors) declined from 77.3 per cent to 63.7 per cent ($P<0.01$); and iron deficiency anaemia prevalence declined from 45.5 per cent to 33.4 per cent ($P<0.01$).

SCALING UP TOWARDS NATIONAL COVERAGE

Based on the success of the pilot programme, Kyrgyzstan scaled up its MNP programme to national scale,[68] reaching 205,000 children 6-23 months old in 2014.[69] The programme continued to include the same rigorous monitoring and evaluation system developed for the Talas province pilot programme. Based on administrative data, this system tracks the supply of MNP product, number of children who have received MNP, number who refused, and the number of medical workers and village health committee volunteers who participated in training. These data are being complemented and triangulated by Lot Quality Assurance Sampling.[70]

In terms of human resources, the UNICEF programme team included a health and nutrition specialist, a monitoring and evaluation officer, a communication for development officer, as well as

support from nutrition advisors at headquarters and the regional office. Other human resources included epidemiologists and a statistician from CDC, nutrition experts from the Kyrgyz Ministry of Health, and a statistician with expertise in survey design and implementation, among others. In terms of financial resources, US$600,000 was used for programmatic activities and approximately US$3 million was used for the supply of MNP over the course of the national programme.

According to preliminary results of the 2013 impact evaluation survey, the prevalence of iron deficiency (as measured by low ferritin levels) decreased by 16.4 percentage points and iron deficiency anaemia prevalence decreased by 8.3 percentage points. The preliminary findings demonstrate the positive results of home fortification programmes on a national scale.

LESSONS LEARNED

UNICEF has learned a number of lessons over the course of this programme. Firstly, pilot programmes should be designed, as this one was, with programme scale-up in mind, and such programmes should document experiences and results to garner support by decision makers. Second, high-level decision makers and beneficiaries should be involved in the planning and assessment of results phases in order to most effectively harness their support for the programme. Third, MNP interventions are best started before the diarrhoea season to avoid potential associations between MNP use and increased diarrhoea. Fourth, medical doctors should be involved from the beginning of the process in order to address any resistance by those who favour strictly curative approaches to anaemia control. Fifth, a locally accepted name is important in stimulating demand for MNP, and the patenting of this name may be necessary in order to prevent abuse. Sixth, integrating MNP interventions into existing government systems enhances long-term sustainability of the programme.

MOVING FORWARD

While the national programme currently provides MNP for free through the public sector, the Government of Kyrgyzstan (with UNICEF's support) is planning to shift to a combination of both free and market distribution of MNP. The shift will ensure scalability and sustainability. In addition, a market-based approach is expected to complement public-sector free distribution by catalysing demand and creating a market for which the private sector can provide. The combination will allow for better coverage of vulnerable groups, as those in middle and higher wealth quintiles are expected to purchase, therefore freeing up additional resources to serve those most in need.

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on Soil Transmitted Helminths, and Global Micronutrient Alliances including the Micronutrient Forum, Home Fortification Technical Advisory Group, Global Alliance for Vitamin A, and the Food Fortification Initiative. UNICEF drove the harmonization of efforts for addressing iodine deficiency disorders with the creation of the Iodine Global Network and served on the boards and steering committees of GAIN, the Flour Fortification Initiative, MI and the Micronutrient Forum.

ANAEMIA REDUCTION

Supportive national policies and legal frameworks are important building blocks in fostering an enabling nutrition environment, and policies around anaemia reduction are particularly important, given the high prevalence of anaemia among children under 5 years, non-pregnant women and pregnant women (estimated at 43 per cent, 29 per cent and 38 per cent, respectively). A key indicator for success in strengthening political commitment, accountability and national capacity for scaling up nutrition interventions is the number of countries with a policy or plan targeting anaemia reduction in women and girls. In 2014, 60 per cent of countries (74 out of 123) had a current national policy or plan to address anaemia in women of reproductive age. In addition, 46 per cent of those countries (34 out of 74) have a specific approach for addressing anaemia among adolescent girls within that national policy or plan.[72]

There are some important country examples of progress in policy development over the reporting period. In Congo, UNICEF's multi-year support to the Government culminated in legislation being passed in 2014 to require fortification of industrially milled wheat flour with at least iron. UNICEF is also supporting the Government to ensure that imported wheat flour is fortified as well. Such programmes have been shown to reduce the prevalence of anaemia among women of reproductive age at a national level,[73] and therefore bear great promise for women in Congo. In Guyana, following the Ministry of Health's approval of a national micronutrient study, UNICEF supported a revision of the Anaemia National Policy, the first draft of which will be available by the end of 2015. In Cape Verde, the National Food and Nutrition Plan, established in 2014 with UNICEF support, provides for interventions addressing anaemia in women of reproductive age. In India, UNICEF partnered with the Ministry of Health and Family Welfare to implement the National Iron Plus Initiative to combat the public health challenge of iron deficiency anaemia prevalent among infants and young children, adolescent girls, women of reproductive age, and pregnant and breastfeeding women.

There is growing evidence to suggest that multiple micronutrient supplements have similar benefits for anaemia reduction as standard iron and folic acid supplementation, and they provide additional benefits for pregnancy. In 2014, UNICEF supported a global inter-agency effort led by MI to prepare for the anticipated policy change from iron and folic acid supplementation to multiple micronutrient supplements during pregnancy. The working group will continue to review the regulatory environment, transition planning and budgeting, production and procurement, supply chain management and logistics, demand generation, and training of health workers. Coupled with recent improvements that have been made to the standard iron and folic acid product, such as smaller bottle sizes, the introduction of multiple micronutrient supplements is expected to lead to increased effective coverage, with resultant benefits for anaemia control and pregnancy outcomes.

SALT IODIZATION

The iodization of all salt for human consumption is the main strategy to combat iodine deficiency disorders (IDD) and UNICEF and a diverse group of public and private-sector organizations are working to eliminate iodine deficiency through universal salt iodization (USI). Globally it is now estimated that about three quarters of households consume adequately iodized salt.[74] UNICEF has a long history of supporting salt iodization programmes. The introduction of these programmes globally has led to dramatic public health gains: as recently as two decades ago, 110 countries were classified as iodine deficient, yet this number has been reduced to 25 according to most recent data.[75] UNICEF is determined to further advance this progress, address new challenges and help ensure that within countries, all population groups have access to adequately iodized salt.

At the global level, UNICEF led the harmonization of efforts by multiple agencies to address iodine deficiency disorders with the creation of the Iodine Global Network. In partnership with GAIN, UNICEF also addressed challenges related to salt iodization in 13 priority countries with a high burden of iodine deficiency. As part of this work, UNICEF

developed a global database to track the performance and related barriers of salt iodization programmes; supported global efforts to harmonize programmes to reduce salt consumption (to prevent cardiovascular diseases) with those promoting salt iodization; and refocused communications programmes on key actors along the supply chain. At regional levels, UNICEF worked closely with regional economic bodies to align regional standards on salt iodization in an effort to improve the availability of adequately iodized salt.

At the country level, support for salt iodization programmes remains strong, as evidenced by the fact that 86 per cent of countries surveyed in the aforementioned global tracking exercise require all the salt available in the country for human consumption to be iodized by law.[76] However, continued advocacy is needed to keep salt iodization on the policy agenda and to further improve the quality of salt iodization programmes. As an example, while the People's Republic of China has one of the most successful salt iodization programmes in the world, continued vigilance is needed to sustain the success. In 2014, UNICEF China helped convene an International Workshop on the IDD Prevention and Control Strategy to maintain a clear focus on mandatory salt iodization in the context of a changing salt industry and to advocate for reaching the estimated 30 million people who still do not have access to iodized salt. Zambia has made major strides under the USI programme. The programme has built capacity for regulatory salt monitoring and on-spot quantification of iodine in salt at the Botswana and Namibia borders, which receive 98 per cent of the salt imports. India has seen continued progress in iodized salt production, with recent data from the salt department showing that up to 85 per cent of iodized salt is meeting quality standards.[77] In Bangladesh, the proportion of households consuming iodized salt increased from 82 per cent in 2013 to 91 per cent in 2014.[78] In China, the coverage of households consuming adequately iodized salt continues to be high at 97 per cent.[79]

UNICEF is able to contribute to breakthroughs in other settings where IDD is common and coverage of iodized salt has remained low. As an example, about one third of school-age children in Ethiopia living in endemic regions have goiter, one of the most visible signs of iodine deficiency, and many more are at risk of poor cognitive development. In the past decade, only 15–20 per cent of households were using adequately iodized salt. However, support offered by UNICEF and other development partners in recent years is beginning to produce results. Ethiopia's preliminary evaluations implemented in 2014 indicate that most of the salt consumed by households now contains iodine. This information is also supported by production data illustrating stark increases in the production of iodized salt. Specifically, iodized salt production and distribution coverage improved from 30 per cent in 2012 to more than 95 per cent in 2014.[80] UNICEF and partners will further validate these findings and continue the programme support in future years.

VITAMIN A SUPPLEMENTATION

In December 2014, UNICEF took part in a meeting of the Global Alliance for Vitamin A (GAVA) to address urgent policy gaps related to VAS. A key objective of the meeting was to finalize the framework[81] for shifting from high-dose supplementation delivered every four to six months, towards the sustained elimination of vitamin A deficiency. Using data on vitamin A intake, vitamin A status, and under-5 mortality, the framework helps maintain support for VAS in settings where this intervention is still required to control under-5 mortality, and provides guidance to programme managers on the conditions under which universal VAS among children 6–59 months old is no longer necessary. For settings where sustained improvements in vitamin A intake and status, as well as child survival, have been made, the framework will inform policies to refocus programmes on specific subgroups defined by geography (e.g., if some regions still suffer poor indicators despite improved national averages) or age (e.g., if vitamin A deficiency prevails only among children 6–24 months old). The GAVA partners are planning to publish the final framework, as well as a related scientific brief and programme guide, by mid-2015.

In addition to supporting the GAVA framework on VAS, in 2014 UNICEF engaged in policy dialogue to support and defend the evidence on this intervention. After a group of researchers criticized large-scale VAS programmes among children 6–59 months old, UNICEF contributed to publishing a rebuttal of the original paper,[82] and led the development of an inter-agency guidance brief for policymakers. In addition, UNICEF drew on its extensive global network of regional and country offices to maintain support for this intervention, and is currently contributing to the development of a manuscript that defines the future of VAS programmes.

FOOD FORTIFICATION

More and more countries are enacting policies and legislation on food fortification to ensure the inclusion of essential micronutrients into staple foods. Georgia, for example, will be finalizing an amendment of their fortification law in the spring of 2015 partly as a result of UNICEF lobbying with Parliament for the enforcement of mandatory national flour fortification.[83] Overall in 2013 and 2014, 82 countries had legislation to mandate staple cereal fortification (at least one industrially milled cereal grain).[84]

UNICEF and the Flour Fortification Initiative (FFI) developed a five-year strategic plan starting from 2013, and UNICEF facilitated rebranding and changing of the FFI name from Flour Fortification Initiative to Food Fortification Initiative to reflect the extension of the FFI mandate from flour to rice fortification. In 2014, UNICEF worked to shape the food fortification agenda globally and advocated for better monitoring systems.

As more countries implement flour fortification programmes, there is an increasing demand to have robust monitoring systems to monitor investments and ensure timely feedback and improvements; UNICEF and partners are working to fill this critical gap. To illustrate,UNICEF, FFI and CDC worked together in 2014 to develop three case studies on monitoring flour fortification with the objective of assessing the monitoring systems in three countries (Chile, Indonesia and South Africa), as very little information is available on how fortification monitoring operates in real-world settings.[85] Although monitoring should be an integral part of any fortification programme, few countries have functioning flour fortification monitoring systems. The results obtained point to required improvements in the areas of monitoring, planning, budgeting, human resources and political will.

REFLECTIONS AND LESSONS LEARNED

A review of micronutrient programmes in 2014 shows that momentum is building in countries to scale up MNP interventions. Micronutrient programmes fill a crucial gap in the programmatic landscape to address iron and other micronutrient deficiencies among children, and to improve the quality of IYCF programmes. As current programmes expand and new programmes emerge, there is a continued need to ensure quality implementation and to document experiences and best practices. Continued technical support from regional and global offices and partners will provide important support to achieving these objectives.

Salt iodization remains the major programmatic approach to control iodine deficiency disorders worldwide. Even though most recent global analyses indicate that coverage of iodized salt is similar across income quintiles, efforts need to be extended to reach population groups that are currently not covered with adequately iodized salt. Programmes and data systems also need to better capture the role of iodized salt consumed through processed foods, given that consumption of such salt is increasing in many parts of the world. Lastly, there is evidence that salt iodization and salt reduction programmes (to reduce the incidence of chronic diseases) can be effectively harmonized, and this evidence needs to be put in practice in programme development.

As under-5 mortality and dietary intake of vitamin A improve, universal VAS among children 6–59 months old may no longer be required in specific settings. Rather, approaches may be indicated in such settings that target children based on geography, younger age, or other criteria. Guidance is under development to support such decision-making. On the other hand, universal VAS among children must remain a priority for child survival in settings where under-5 mortality and poor dietary vitamin A intake are common.

PROGRAMME AREA 4 – NUTRITION IN EMERGENCIES AND MANAGEMENT OF SEVERE ACUTE MALNUTRITION[86]

The burden of SAM is high in both emergency and development settings, affecting approximately 17 million children worldwide.[87] Children suffering from SAM are more susceptible to disease and have weakened immune systems, which can cause cyclical illness as well as long-term developmental delays. SAM remains a major cause of mortality among children under 5 years of age, particularly in emergencies – and much of it can be prevented.

In 2014, UNICEF continued to support the expansion of services to manage SAM in emergency and non-emergency settings. In particular, services to treat SAM at community level have continued to expand, and are increasingly being integrated into health systems. The treatment of SAM without medical complications through the use of RUTF is one of the main direct nutrition interventions of the community-based management of acute malnutrition (CMAM) approach. With the advent of decentralized outpatient care models, the number of SAM cases receiving treatment has significantly increased in the past decade.[88] In 2013, 2.91 million children were admitted for treatment of SAM, an increase of more than 300,000 cases from the previous year.[89] Of these, UNICEF supported 2.68 million admissions.[90]

UNICEF's actions in the programme areas of nutrition in emergencies and SAM are critical to achieving success in Outcome 4. UNICEF works closely with governments and partners to integrate SAM treatment into health systems, lead policy change, provide technical support, and act as the major provider of therapeutic foods. Alongside investments in the treatment of SAM, increasing emphasis is put on the prevention of acute malnutrition through strengthening the continuum of care for acute malnutrition (severe and moderate) and multi-sectoral coordination in order to reduce the global burden of SAM.[91]

UNICEF works with partners in emergency settings to assess, analyse, design and deliver key nutrition interventions, and evaluate the emergency nutrition response. Through its Core Commitments for Children (CCCs) in Humanitarian Action framework, UNICEF supports access to essential and quality nutrition services before, during and after an emergency. This involves assessing the nutritional and health needs of affected populations to determine the necessary response, and working to ensure that women and children have equitable access to services, including through timely provision of essential supplies.

Over the past year, UNICEF continued to respond to humanitarian emergencies, both programmatically and through fulfilling its cluster lead role for nutrition. The magnitude of humanitarian needs in 2014 strained the agency's capacity to respond in the face of multiple large-scale level 2 and level 3 emergencies, underscoring that systematic investments in preparedness, staff capacity development and risk-informed programming must be sustained. In 2014, UNICEF deployed an additional 58 individuals (including staff drawn from within the organization and externally) to support nutrition programmes in emergencies, and another 22 were deployed to support cluster coordination.

NUTRITION IN EMERGENCIES AND SAM OUTPUT-LEVEL RESULTS

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

SAM MANAGEMENT IN EMERGENCY AND NON-EMERGENCY SETTINGS

In 2014, UNICEF continued to support countries in expanding SAM programmes to serve more children, and to position SAM management within a comprehensive nutrition package that is delivered to vulnerable groups as needed, in line with the country context. UNICEF's support to SAM management includes building the capacity of the host government and local actors to scale up SAM programmes, facilitating the development

and application of norms and standards, capturing lessons learned, and promoting information and knowledge management to contribute to increased reach, coverage and quality of programmes. A key indicator for this output on country capacity and service delivery is the number and percentage of UNICEF-targeted children age 6–59 months with SAM in humanitarian situations that are admitted to programmes for management of acute malnutrition and recover. In 2014, more than 81.5 per cent of targeted children (2.29 million from a target of 2.81 million) were admitted for treatment of SAM in humanitarian situations. This achievement should be also seen within the context of the global SAM burden (spanning development and humanitarian settings) of 17 million,[92] the ongoing situation of heightened food and nutrition insecurity in the Horn of Africa, and the alarming nutritional status of children in the Sahel, with SAM prevalence exceeding emergency thresholds in several regions even in years of good harvest. Although 66 per cent of all severely wasted children live in Asia,[93] the number of children admitted for treatment in Asia accounts for only 13 per cent of total reported admissions.[94]

According to current estimates, 75 countries are providing SAM management services with UNICEF support.[95] Following is a snapshot of some country-level achievements in SAM management:

- In Burkina Faso: between 2010 and 2014, the proportion of districts with more than 50 per cent coverage of children with SAM increased from 22 per cent to 60 per cent. SAM cure rates were 90 per cent for outpatient and 85 per cent for inpatient, and death rates were 5 per cent for outpatient and 10 per cent for inpatient. These positive results are mainly due to the implementation of the national scale-up plan of SAM management in all the 13 regions, the continuous availability of RUTF, quarterly screening in all health districts and improved coordination among nutrition sector partners.
- In Burundi: in 2014, a total of 32,957 children (72 per cent of the 46,000 expected caseload) suffering from SAM benefited from UNICEF-supported CMAM programmes nationwide, out of which 18,193 were from the nine USAID/Food for Peace target provinces. The proportion of SAM children cured is higher than the SPHERE 2011 recommendation, with 90 per cent cured nationwide and 91 per cent in the USAID-Food for Peace targeted provinces.
- In the Democratic People's Republic of Korea: UNICEF supported the upgrading and endorsement of the CMAM technical guidelines, and SAM services were delivered in 1,000 service delivery sites in 29 counties in four northeastern provinces (with the highest burden of SAM cases) as well as in 14 baby homes, 29 county hospitals and 12 provincial paediatric hospitals across the country. Some 16,000 SAM-affected children were treated, representing about 70 per cent of the annual caseload. UNICEF helped to improve the quality of SAM services by facilitating the capacity development of master trainers and health workers, ensuring availability of nutrition supplies and in-country logistics.
- In the Democratic Republic of the Congo: UNICEF and its partners continued to rapidly scale up SAM treatment, providing treatment to 296,000 children affected by SAM (99 per cent of the target and approximately 17 per cent of the annual estimated caseload) in 2014, (up from 254,000 in 2013 and 227,000 in 2012), with a cure rate of 85 per cent. Increased funding will be critical for expanding coverage and ensuring life-saving treatment. In parallel, to decrease the caseload and strengthen resilience, the current promotion of appropriate IYCF practices and other interventions (e.g., hand washing with soap, use of bed nets, ORS with zinc) will need to be scaled up.
- In Nepal: as of October 2014, approximately 8,321 children under 5 (boys: 3,634 and girls: 4,687) with SAM were admitted into outpatient therapeutic programme centres in the 11 integrated management of acute malnutrition districts, and of these, 7,539 (boys: 3,286 and girls: 4,253) were discharged. Of the total discharged, 99.7 per cent survived and just over 86 per cent recovered, which is well above global sphere humanitarian standards.[96]
- In Nigeria: a total of 320,247 children with SAM (representing 99 per cent of the annual target) were treated across 11 northern states. The national burden of SAM was estimated to be over 6.1 million in 2013. Programme performance indicators show that cure rates improved from 79 per cent to 84 per cent, the defaulter rate improved from 17 per cent to 13 per cent, and the death rate remained at 1 per cent. These exceed the annual targets and are in line with sphere humanitarian standards.
- In South Sudan: despite numerous challenges such as insecurity, limited access and operational capacity, UNICEF South Sudan, with its implementing partners, admitted 93,204 children for SAM treatment, representing 53 per cent of the 2014 target and 40 per cent of the annual SAM burden for children 6–59 months old. This achievement is the result of the remarkable scale-up of the nutrition response, especially in conflict-affected states,

in terms of improving the supply chain of RUTF, revamping the nutrition information system, and improving internal capacity both at national and state level.

- In Yemen, UNICEF and partners scaled up SAM treatment by building the capacities of an additional 1,993 health staff and extending the programme to 501 facilities in 2014 compared with only 35 in 2012. SAM performance indicators in Yemen improved in 2014, with the cure rate rising 5 per cent from the previous year (from 64 per cent to 69 per cent) and the defaulter rate decreasing in the same period from 32 per cent to 27 per cent. Trained community health volunteers were recognized as key to improving the social mobilization and tracing of defaulted children, and this decentralized approach was an important factor in the overall success of the programme scale-up.[97]

IYCF AND MICRONUTRIENTS INTERVENTIONS IN EMERGENCIES[100]

One of the Strategic Plan 2014–2017 indicators for country capacity and service delivery is related to the number and percentage of UNICEF-targeted children between 0–23 months in humanitarian situations who are accessing IYCF counselling for appropriate feeding and early childhood development services. In 2014, 6.6 million UNICEF-targeted caregivers of children age 0–23 months accessed infant and IYCF counselling in humanitarian situations. Of those caregivers, 1.49 million received counselling that included early childhood stimulation and development services, and 3.3 million received IYCF counselling or attended a group education session on IYCF.[101] Nationally in the Philippines in 2014, UNICEF supported 102,684 caregivers of children 0–23 months (of a target of 168,300) with IYCF counselling for appropriate feeding as part of humanitarian action. Of these, 75,641 caregivers were supported as part of the Typhoon Haiyan response. The Haiyan response highlighted the limited access to clean water and food in key areas which threatened pre-existing IYCF practices, thus the need for increased focus on WASH and nutrition interventions. UNICEF Lebanon also trained 30 UNICEF partners and Ministry of Public Health staff on nutrition and IYCF in emergencies through collaboration with the American University of Beirut. In Burkina Faso, as part of the Sahel nutrition response, UNICEF with partners supported the development of the IYCF scaling-up plan creating an enabling environment to boost key IYCF practices. In 2014, 146,000 pregnant women and 236,000 mothers with children 0–23 months old (100 per cent of the target) participated in monthly learning sessions on IYCF. According to the annual nutrition survey, early breastfeeding has increased from 29.2 per cent in 2012 to 41.6 per cent in 2014, exclusive breastfeeding from 38.2 per cent in 2012 to 50.1 per cent in 2014, and the minimum adequate diet among children 6–23 months old from 3.2 per cent in 2012 to 11.4 per cent in 2014. The promotion of optimal IYCF practices in emergencies is a cross-cutting area in nutrition programming, and is addressed further in programme area 2.

UNICEF also plays an important role in supplying key micronutrients in emergencies. For example in Afghanistan, just under half (48 per cent, or 342,456 out of 706,996) of targeted children 6–59 months old were reached with MNP supplementation, in five provinces. The challenges faced in attaining the targets for nutrition in emergencies include supply stock-outs (due to difficult logistics of road transport from Pakistan to the SAM sites), limited outreach work (as community health workers are overburdened and not incentivized), and insecurity and funding constraints, which delayed capacity development of partners in nutrition in emergencies.[102] In the Gambella region of Ethiopia, the Regional Health Bureau, with UNICEF support, provided VAS to 67,000 refugee children between the ages of 6 to 59 months (from a target of 64,400) at the border crossing points and refugee camps.[103] In the Niger, linked to polio immunization, VAS and deworming were provided twice a year throughout the country to 4.6 million children age 6 to 59 months (of a target of 4.9 million). In the Sudan, 6.5 million children 6–59 months old received VAS twice a year in 2014, resulting in 99 per cent coverage. A notable success was an increase in coverage from less than 65 per cent to above 80 per cent in 52 low-coverage areas. In 2014 in Uganda, in response to worsening food and protection concerns, UNICEF supported more than 244,000 children (from a target of 238,000) with VAS and deworming – including both refugee and host community children as well as children in the Karamoja District.

RESILIENCE BUILDING

In Burkina Faso, UNICEF led the development of a joint initiative to build resilience in the Sahel administrative region both internally, across all programme components, and externally, through a

BACKGROUND AND RATIONALE

On 15 December 2013, violence broke out in South Sudan's capital Juba, quickly spreading to three states. By February 2014, the violence had displaced 1.5 million people and resulted in alarming rates of child malnutrition.[98] Estimates from the Integrated Food Security Phase Classification forecast showed that the nutrition situation would deteriorate sharply in counties in the most affected states of Unity, Upper Nile and Jonglei if nutrition services were not scaled up – in particular given that seasonal rains and flooding in the second half of the year would hamper aid operations by making about 60 per cent of the country inaccessible by road.

In order to accelerate their response, UNICEF and WFP initiated a planning process in June, engaging country, regional and headquarters expertise. In consultation with the Nutrition Cluster and cluster partner agencies, and under the Nutrition Cluster Response Plan, UNICEF and WFP defined their operational partnership to address gaps in nutrition services. The planned interventions were outlined in a UNICEF/WFP Nutrition Scale-Up Plan aiming to reach 176,000 children with SAM and an additional 420,000 children with moderate acute malnutrition (MAM) within a six-month period. Internal capacity and systems that each agency would need to augment in order to effectively engage with partners and promote effective service delivery were outlined as well. In addition, as cluster lead agency, UNICEF mobilized ongoing support for coordination and information management in order to lead partners to fulfil the three objectives of the Nutrition Cluster Response Plan:

- Deliver quality, life-saving management of acute malnutrition for at least 75 per cent of SAM cases and at least 60 per cent of MAM cases in all children under 5;
- Provide programmes for the prevention of malnutrition for at least 80 per cent of vulnerable people;
- Ensure enhanced needs analysis of the nutrition situation, and enhanced coordination and monitoring of the response.

STRATEGY AND IMPLEMENTATION

A series of consultations with the cluster coordination team and implementing partners identified bottlenecks in respective areas of operation, along with specific steps that WFP and UNICEF as well as implementing partners would take to rapidly scale up response in the 44 priority counties. The UNICEF/WFP Nutrition Scale Up Plan identified seven key strategies to fast track the scale-up process, including:

i. Optimize nutrition services with existing partners;

ii. Expand operational partnerships (including engagement of health cluster partners);

iii. Improve community outreach and screening/referrals;

iv. Provide technical support to enhance service quality;

v. Strengthen existing supply chain/pipeline management;

vi. Direct provision of services – Rapid Response Mechanism (RRM); and

vii. Enhance needs analysis and support for coordination.

PROGRESS AND RESULTS

The collaboration between UNICEF and WFP resulted in an increased pace of the response and resource mobilization in a very short period of time, despite the numerous challenges of the emergency.

The availability of SAM treatment increased exponentially, with monthly admissions increasing from approximately 1,000 children in January to 17,000 in December. In order to accommodate this expansion in programming, existing partnerships were amended to increase geographic coverage and target numbers, and new partnerships were sought to address gaps. Through improved supply chain management, stocks of RUTF and ready-to-use supplementary food were made available to partners and strategically prepositioned in key locations, taking into account the volatile situation.

By December 2014, through capacity-building initiatives, a total of 1,865 partner and Ministry of Health staff were trained in various aspects of prevention and treatment of acute malnutrition, supply management, as well as data management, monitoring, assessments and reporting.

Between March and December 2014, UNICEF, WFP and implementing partners carried out 34 joint Rapid Response Missions (RRMs) that resulted in direct service delivery to more than 603,000 people, including 132,000 children under 5, all in hard-to-reach areas in conflict-affected states. During these

missions, 77,444 children were screened for malnutrition, of which 4,619 were severely acutely malnourished. Newly identified cases of SAM and MAM were admitted into programmes for treatment.

The national Ministry of Health Social Mobilization Network (SM-Net) intensified its outreach activities in three states. This network consists of approximately 1,500 social mobilizers and supervisors. By March 2015, 256 trained social mobilizers reached 54,738 households through house-to-house visits, promoting IYCF and WASH practices at household level and screening 81,995 children under 5. In Juba, they identified 867 children (1.1 per cent) suffering from MAM and 245 children (0.3 per cent) from SAM and referred them for treatment.

In 2014, a total of 50 SMART surveys were conducted and technical support provided to partners to ensure quality data collection of nutrition indicators. The findings were included in the Integrated Food Security Phase Classification analysis.

RESOURCES

UNICEF and WFP deployed surge staff to support the joint Nutrition Scale-Up Plan and make sure that critical functions were covered. Procedures to identify and recruit staff for longer-term placement were fast-tracked. The nutrition teams of both agencies were expanded drastically to ensure that nutrition expertise was present at all RRM missions and that field offices were adequately staffed to provide technical support to partners, enhance monitoring and oversight, and strengthen coordination at the subnational level.

Resources were invested in improving supply chain management, including additional warehousing, and transporting supplies to partners' implementation sites, including airlifts. UNICEF required US$43 million[99] to implement the joint Nutrition Scale-Up Plan.

LESSONS LEARNED

UNICEF's experience in South Sudan highlights the importance of having skilled staff on the ground, including a supply/pipeline nutrition manager, in large-scale SAM programming. Having to mobilize a large-scale response underscored the need for ongoing investment in UNICEF's surge mechanisms alongside greater investments in human resources and national capacity in nutrition, as per the CCC framework. Joint planning by the two agencies was crucial to ensure a continuum of care for acute malnutrition and to integrate IYCF as part of the package to treat and prevent malnutrition. UNICEF and WFP were able to make the contribution to the Nutrition Cluster response due to their enhanced partnership also demonstrated the importance of systematically operationalizing the existing global memorandum of understanding between the two agencies.

It was evident that in a context of both insecurity and flooding, transparent and timely communication between partners, United Nations agencies and donors is adamant to mitigate interruptions in services and supplies, caused by access problems or pipeline breaks. In addition, timeliness of funding was crucial to enable large-scale pre-positioning of supplies in advance of the rainy season and to allow access by air when needed.

The experience in South Sudan also highlighted the important role of SMART surveys and routine nutrition information, in addition to integrating nutrition into other sectoral surveillance systems like the Food Security Monitoring System. This is critical to better inform the response based on the nutrition situation rather than food security alone. Most fundamentally, engagement of the national government in all aspects of the response provided an opportunity to institutionalize capacity and standards in a humanitarian context and to support national capacity for emergency preparedness and response.

MOVING FORWARD

The nutrition situation for children in South Sudan remains dire in 2015. Any significant increase in violence would cut off supply routes, disrupt markets and hinder access to services, a situation likely to become quickly catastrophic for acutely malnourished children and lead to high levels of mortality. In May 2015, WFP and UNICEF will hold a review meeting on the progress of the UNICEF/WFP Nutrition Scale-Up Plan. The review will evaluate the respective organization's operational plan and guide action in 2015. In the meantime, the following key activities below are planned or being carried out:

- UNICEF and WFP are continuing to develop guidelines, tools and standard operating procedures based on lessons learned from RRM missions.
- Capacity-building efforts are being made to strengthen the provision of services by implementing partners and the Government of South Sudan. Key focus areas for 2015 include building partners' capacity and ability to deliver high-quality nutrition interventions by increasing oversight missions and on-site trainings, and supporting the Government in the revision of the national CMAM and IYCF guidelines.
- WFP and UNICEF are continuing to actively identify partners where major service coverage gaps exist.

- Human resources will be seconded to the Ministry of Health, to assist the department of nutrition in implementing and coordinating nutrition activities.
- Social mobilization interventions continue to be scaled up in high-burden areas and will be expanded to another state.
- IYCF counselling will be systematically scaled up through various modalities, including in Protection of Civilians sites and sites for internally displaced people; during RRMs; and through state Ministry of Health social mobilizers.
- The Expanded Criteria, which outlines programme options to treat SAM where there is only MAM programming and vice versa, have been endorsed by the Ministry of Health and will serve as a modality to provide systematic treatment for all children under 5 with MAM. In addition, WFP and UNICEF are ensuring that as much as possible, common partners provide treatment for SAM and MAM.

RELATED LINK

Nutrition cluster scale-up plans:

www.humanitarianresponse.info/operations/south-sudan/document/ssudan-updated-nutrition-cluster-response-plan-final-draft-1-sep

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memorandum of understanding signed with WFP, FAO and WHO, and a 2014 joint action plan in nutrition with a focus on the three most vulnerable regions (North, Sahel and East). Moreover, the four United Nations agencies have developed a joint nutrition concept note on a United Nations strategy for resilience and are actively involved in the REACH initiative to assist governments to accelerate the scaling up of food and nutrition interventions. A needs assessment was conducted and the REACH initiative for Burkina Faso was set up by advocating for better understanding of the multidimensional aspects of nutrition and the criticality of nutrition-sensitive sectors' commitment (Health, Food Security-Agriculture, WASH, Social Protection and Education). This 'call for action' acknowledged in the REACH Country Implementation Plan, shared with the government and partners, was the building block of a common results framework and multi-sectoral coordination platform for nutrition (the National Consultative Council for Nutrition), co-chaired by UNICEF, ACF and Spell out.[104]

In the Niger, as lead of the Nutrition, WASH, Education and Protection Clusters, UNICEF played an important role in ensuring coordination between all partners to avoid duplication in the emergency response. Collaboration was particularly strong among United Nations agencies, with a clear repartition of tasks. This partnership was strengthened in 2014 with the implementation of the 'convergence municipality' approach, which aims to build the resilience of vulnerable communities. In 2014, following a participatory needs assessment and planning process, 11 municipalities benefited from integrated humanitarian and development interventions from the Government of the Niger, UNICEF, other United Nations agencies and NGO partners.

In Somalia, UNICEF is implementing the Joint Resilience Strategy for Somalia alongside WFP and FAO to strengthen household and community resilience. UNICEF's contribution within the joint strategy spans across the three pillars, with a focus on activities to improve basic social services and establish predictable safety nets (the second and third pillar). Social services are a necessary aspect of resilience building, as they serve to enhance human capital, recognizing that educated, healthy, well-nourished people have a better capacity to work, sustain and adapt their livelihoods in reaction to or preparation for shocks. The resilience programme builds public health, education, protection and governance capacities at local level. This contributes to emergency preparedness as local communities become less dependent on outside interventions and more capable of absorbing these interventions when the emergency surpasses local capacity.

A basic cadre of community-based frontline service providers in public health, education and protection has been put in place across the Bakool, Bay, Gedo and Hiraan regions of Somalia. In order to support and sustain these efforts, UNICEF builds the ability of the community to jointly plan, monitor and oversee local solutions to local challenges by fostering, training and accompanying local community committees. The involvement of community in the design, delivery and monitoring of the resilience programme is in line with rights-based programming and, in the context of Somalia, helps to bridge the chasm between emergency response and development programming.

GENDER

UNICEF takes gender dimensions into account in programming and response to emergencies and humanitarian situations. In 2014, UNICEF's Latin America and Caribbean Regional Office supported and strengthened country office capacity in the prevention, mitigation and response to gender-based violence, particularly within the humanitarian clusters, including nutrition, led or co-led by UNICEF. In another example, as part of a broader training on SAM management in Haiti, a number of staff were trained on managing and responding to cases of gender-based violence.

NUTRITION INFORMATION

In 2014, UNICEF continued to develop capacity for improving nutrition information and data collection in emergencies. For example, UNICEF conducted two regional workshops in East and West Africa on routine coverage surveys and bottleneck analysis to improve SAM programme management. In the Middle East and North Africa (MENA) region, UNICEF conducted SMART[105] methodology training with the support of the CDC and ACF Canada, benefiting 27 participants from 10 MENA countries. To strengthen SAM nutrition information systems, Programme Division supported the Malawi office in a bottleneck analysis exercise to inform the development of the National 2015–2020 CMAM Operational Plan.

UNICEF and its country partners are also using innovative strategies such a mobile technology to improve information and data collection. In Nigeria in 2014, UNICEF leveraged the power of mobile devices to support the national nutrition and health survey. Compared with the traditional paper surveys, mobile devices allowed UNICEF to significantly reduce costs, improve the timeliness of results and enhance overall data quality.

TECHNICAL GUIDANCE AND LEADERSHIP

Some of the most important leadership provided by UNICEF in 2014 was related to the Ebola outbreak in West Africa. The Nutrition Section at headquarters and the regional office worked closely with WHO, WFP, ENN and other partners to develop guidance on different aspects of nutrition in the context of Ebola. Key guidance documents include: Joint (WHO/UNICEF) guidance on Infant feeding in the context of Ebola;[107] and 2) Joint (WHO/UNICEF/WFP) guidance on Nutritional Care of Children and Adults with Ebola Virus Disease in Treatment Centres. The regional office led the development of adapted guidance for the treatment of SAM in the context of Ebola.[108]

On the ground in Liberia, UNICEF, through collaboration with WHO and NGO partners, advocated for the revision of local nutrition policies for use during the outbreak period. UNICEF, leading the coordination of the Nutrition Sub-Cluster, organized technical meetings to review global nutrition guidelines and understand Ebola-related nutrition practices in order to develop modified protocols. By mid-November 2014, modified policies on nutrition were completed and endorsed by government.[109]

UNICEF also played a key role in the September 2014 regional inter-agency consultation on emergency food security and nutrition preparedness and response in the Horn of Africa, with FAO, the UN Refugee Agency, WFP and the United Nations Office for the Coordination of Humanitarian Affairs. In addition, UNICEF contributed to the production of other guidance documents on nutrition in emergencies and the management of SAM. As co-lead of the United States-based nutrition partners group, UNICEF contributed to developing interim guidance on operational responses where SAM and/or MAM programmes are absent. UNICEF also produced programme guidance on scaling up SAM treatment (currently in design and translation), and a bottleneck analysis toolkit for SAM services, a joint pilot project with Action Against Hunger, HKI, and the Food and Nutrition Technical Assistance project.

POLICIES, PLANS AND PROTOCOLS

UNICEF also works to strengthen upstream efforts to promote SAM management – for example, by supporting governments to adopt the treatment of SAM on a national and/or subnational level, and advocating for SAM treatment to be prioritized via national planning mechanisms and policies. Progress has been made in this regard over the past few years: 59 countries (of 67 reporting in NutriDash) now include SAM management in their national health and nutrition policies. Despite this important political will, 29 of these countries do not allocate any funding to SAM management within national budgets, meaning that this intervention is still predominantly funded by the United Nations, NGOs and donors.[110] It goes without saying that adequate budget allocation for SAM management and long-term strategies to integrate CMAM into the health system are key factors in translating political commitments and policies into concrete interventions to save lives.

Many countries are developing or updating plans and protocols for improving coverage and quality of SAM implementation. In Ghana, UNICEF supported the first revision of the national CMAM protocols since their introduction in 2008. Among other things, the revisions include new WHO-recommended discharge criteria, which ensure that all children remain in the programme long enough to recover. UNICEF also contributed to a revision of the CMAM protocol in Burundi. In the Sudan, the focus has been on planning the national CMAM Scale-up Strategy in order to improve geographical coverage of CMAM services to reach and treat more children in need. This was led by the Federal Ministry of Health, with technical expertise provided by UNICEF in partnership with WFP. The plan will be rolled out in 2015 in 72 high-priority localities to ensure that the most vulnerable children are targeted.[111]

National strategies and plans for meeting children's nutritional needs in emergencies are also improving in many countries. In Colombia, UNICEF was involved in the development and implementation of the Strategy for Nutritional Care in Emergencies. This strategy included the promotion of breastfeeding and the identification and treatment of children with acute malnutrition and micronutrient deficiencies. In Bangladesh, UNICEF continued strengthening the Government's capacity in emergency preparedness by co-leading the nutrition cluster. Joint contingency and response plans with Food Security and WASH clusters for flood-affected districts were developed, along with standardized national guidelines on nutrition assessments (SMART). A national Rapid Nutrition Assessment Team was established to support the Government's capacity in assessing emerging humanitarian situations in accordance to applicable international standards. Further examples of country progress on nutrition policies that also address crisis risks are discussed earlier in this report under the general nutrition programme.

REFLECTIONS AND LESSONS LEARNED

In 2014, considerable human resources were devoted to emergency response, for UNICEF's dual responsibility for supporting programme response as well as ensuring leadership of the Nutrition Cluster. Surge mechanisms with standby partners and external expertise helped address some of the additional needs, but more often staff and consultant time needed to be redirected to large-scale emergency responses. Identifying and recruiting staff for difficult contexts as well as large-scale programming remained challenging, in particular given the number and scale of concurrent emergencies. As a result, there were delays in the provision of planned technical guidance on nutrition and resilience and post-disaster needs assessment, as well as other activities to support SAM programme scale-up. There is a need to better link humanitarian and development programming, strengthen surge response mechanisms and engage in a more systematic capacity development for nutrition staff to be better enabled to respond to emergencies.

Some lessons learned in countries are also illustrative of the challenges affecting the scale-up of SAM treatment. In Guinea-Bissau, for example, it became clear that strategies to reduce the SAM default rate should involve increasing accessibility to services. This can be achieved by increasing the number of available outpatient treatment centres and strengthening the community case management through the 1,305 community health workers already trained in integrated management of acute malnutrition, including active screening and referral at community level. In emergency contexts, such as that of the Sudan, a major constraint for UNICEF was accessing a large proportion of treatment centres on a regular basis to provide on-the-job training and supportive supervision due to

LEVERAGING THE POWER OF MOBILE DEVICES TO IMPROVE NUTRITION SURVEYS IN NIGERIA

UNICEF responds frequently to nutrition crises across countries in the Sahel and Horn of Africa. For this response to be most effective, it is critical to have regular and high-quality data on nutrition conditions using standard methods and well-trained data collectors. Good data ensure that UNICEF and other partners can put in place resources to treat and prevent annual peaks of acute malnutrition. However, systematic data collection can be expensive and logistically difficult in resource-poor countries. Traditional nutrition surveys are often hampered by poor planning and a lack of standardization, introducing delays in the preparation, collection and reporting of survey data. Moreover, these surveys can often take up to one year or more between data collection and release of results. In situations where programme data are not regularly available, these delays limit the capacity of governments and other agencies to respond to such crises and track progress towards set goals.

With these problems in mind, UNICEF Nigeria developed a SMART phone application for the robust data collection of nutrition and health surveys. Mobile devices are effective in streamlining the planning, training and implementation of the survey, producing final results immediately after completion of data collection. UNICEF's tool is similar to other mobile data collection applications, but includes the calculation and review of anthropometric Z-scores[106] on the mobile device. The device collects data through a purpose-built data entry form. It sends data via 3G networks from the phone to the database hosted on a cloud-based server. As the tool receives data, it assesses data quality in real time and presents results on a nutrition survey dashboard. This review allows survey coordinators to quickly recognize and respond to common errors such as implausible data, inappropriate sampling at cluster or household level and missing clusters. With built-in quality checks and suggested responses, the standardization of survey or nutrition surveillance data is more robust and has greater power to determine where conditions are deteriorating or programming is successfully addressing malnutrition.

The data collection tools were first piloted in February 2014, in one northern state of Nigeria. After changes were made in the data entry forms, the tools were used for national data collection in Nigeria's first National Nutrition and Health Survey, in May 2014. UNICEF employed 27 survey teams, comprising three people each, to conduct the survey using 50 tablet devices. The data entry form and nutrition survey dashboard were developed by eHealth Africa, an international NGO working on eHealth based in northern Nigeria. The survey was representative at the state level plus Federal Capital Territory, meaning there were 37 representative strata. While surveys typically employ at least one team per strata, UNICEF found it more effective to employ a smaller number of highly qualified interviewers and use a roving system. This allowed for the use of only 10 supervisors and 4 regional coordinators from the National Bureau of Statistics, National Population Commission and the Federal Ministry of Health.

LESSONS LEARNED

Nigeria's survey was successful and provided evidence that data collection via mobile devices can significantly address issues of cost, timeliness and data quality. For example, data collection using tablets was roughly half the cost of using traditional paper questionnaires. In addition, the tablets can of course be used again for future surveys. Whereas traditionally accepted methods and tools for national surveys are constrained by time-consuming paperwork, recording errors on paper questionnaires, and data entry and validation, mobile devices are much more efficient and provide timely and better-quality data for responding to nutrition situations. UNICEF estimates that the use of mobile technology has saved it approximately eight weeks of work.

MOVING FORWARD

In future, the aim is for all nutrition surveys in Nigeria to be done on mobile devices. The elimination of paper questionnaires and double data entry and validation dramatically reduces the cost of the survey. The introduction of validation of training methodologies, data quality reviews (including time and place of data collection) ensures the collection of data of the highest quality. The tools can also be easily modified for research or nutrition surveillance activities, and can present important opportunities for other countries working to aggressively address malnutrition.

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insecurity and government restrictions on access, and lack of UNICEF presence in some states. In this particular case, a strategy to improve supervision, through joint mentoring teams, is currently being drawn up with the Ministry of Health.

In 2014, UNICEF reaffirmed the need for a multi-sectoral approach to address the underlying causes of malnutrition in conjunction with expanding quality services for the treatment of SAM. In the Sudan for example, nutrition services have mainly focused on treatment in response to emergencies, while underlying causes particularly in the area of water and sanitation and health services remain largely unresolved. This is particularly true for rural areas and conflict-affected states where the Sudan's most disadvantaged children live. In the Democratic People's Republic of Korea, funding shortages for both nutrition and WASH resulted in low and limited geographical coverage of certain multi-sectoral programme interventions, which undermined efforts to address the interlinked causes of undernutrition and child mortality. In Kenya, the multi-sectoral platform is yet to be operationalized. Coordination presently functions mainly at the Nutrition and Dietetics Unit of the Ministry of Health, limiting the development of a multi-sectoral common results framework for nutrition.

UNICEF continued to identify ways to strengthen the therapeutic supply chain, in particular as it remains the primary supplier of therapeutic products for SAM globally. For example, in Burundi, RUTF storage capacity at health centres and in some district pharmacies is not yet adequate to facilitate integration of SAM treatment into routine services. However, the country's ongoing RUTF supply chain bottleneck analysis is expected to formulate recommendations and strategies to address identified challenges, including the establishment of the 'pull' supply system, where districts will be required to estimate their needs in conformity with current supply chain procedure of other medical supplies.

There have also been a number of technical challenges over the past year in Burundi, as in other countries. The capacity of service providers to estimate RUTF needs is still weak, which means that the supply of RUTF to districts continues to rely on the "push" approach, relying on strong support from UNICEF. In Kenya, UNICEF has supported on-the-job training for health-care workers to improve their nutrition programming skills and contributed to the development of a framework for broader capacity-building initiatives. In Burkina Faso, in order to improve the quality of inpatient treatment of SAM, the Ministry of Health, with support from UNICEF and field partners, will implement field-based formative supervision, ensuring close and regular monitoring of performance indicators and trainings. The need to strengthen food and nutrition security monitoring systems, including building capacities within the Ministry of Health to manage health facility data, is also highlighted in many countries. To address this in Namibia, for example, WFP, WHO and UNICEF are supporting the development of a nutrition surveillance system to ensure that any future emergency and non-emergency routine data will be available.

PROGRAMME AREA 5 – NUTRITION AND HIV[112]

Undernutrition and disease are closely linked. The prevalence and severity of infectious diseases, especially among vulnerable groups such as pregnant women or young infants, are likely to increase as the nutritional situation worsens. In a vicious cycle, malnutrition makes children more susceptible to infection, and infection can also make children more vulnerable to malnutrition. UNICEF's operational approaches (*see Figure 3*) clearly illustrate the need for programmatic action to improve nutrition care for those with infectious diseases. Infectious diseases such as HIV and AIDS and tuberculosis greatly increase malnutrition-related morbidity and mortality in high prevalence areas. Nutrition-sensitive HIV programmes could help identify children with HIV and AIDS early on before becoming symptomatic, thus accessing early HIV and nutrition treatment and care. Proper nutritional screening, treatment and care is also important, especially for pregnant women living with HIV, as this will prevent further negative outcomes for the infant (children born to women living with HIV have slower growth rates, with overall poorer growth at all ages).[113]

Mothers living with HIV and HIV-exposed infants are more prone to undernutrition due to factors such as increased energy requirements, loss of appetite and reduced capacity to metabolize food. At the same time, nutrition is critical in boosting

the immune system to fight the virus. Guidance around nutrition and IYCF for mothers living with HIV and HIV-exposed and HIV-infected children has evolved greatly in the past decade based on research results and programme experiences. The recent widespread availability of antiretroviral drugs (ARVs) now makes it possible for mothers with HIV to breastfeed their infants while minimizing the risk of HIV transmission. In fact, exclusive breastfeeding for the first six months is associated with a threefold or fourfold lower risk of HIV transmission[114] as compared with mixed feeding.[115]

In settings where feeding practices and ARV services are far from ideal, policies, health systems and services providers need to be attuned in order to provide mothers living with HIV the most consistent, accurate and culturally acceptable services and support. Relevant output indicators should collect information for HIV populations and present data disaggregated by HIV status.

HIV prevalence is often highest in countries where exclusive breastfeeding rates in the general population are lowest. Malawi, for example, has an exclusive breastfeeding rate of over 71 per cent[116] and an HIV prevalence rate of just over 10 per cent,[117] while South Africa has an exclusive breastfeeding rate of only 8 per cent[118] and an HIV prevalence rate of over 19 per cent.[119]

Nutrition programming in the context of HIV focuses on the prevention of mother-to-child transmission during breastfeeding and on care and support for infected mothers and HIV-exposed and infected children. Strategies include: 1) providing voluntary, confidential testing and infant feeding counselling for pregnant women; 2) supporting governments in developing IYCF policies that address the needs of mothers living with HIV and HIV-exposed and HIV-infected children; and 3) supporting the development of guidelines, based on the best available evidence to optimize the nutritional needs of HIV-positive pregnant and breastfeeding women and children who are infected with the virus, orphaned, or living with an HIV-infected parent.

PROGRESS IN 2014

In 2014, WHO and UNICEF partnered to review and revise the 2010 HIV and Infant Feeding Guidelines, bringing them in line with recent scientific evidence. UNICEF developed a decision-making tool, including a checklist, for determining the HIV status of children with SAM in emergencies. The tool was included in the UNICEF programme guidance document for the management of SAM in children.

The double dividend initiative, co-led by UNICEF, WHO and the Elizabeth Glazer Pediatric AIDS Foundation, aims to align maternal, neonatal and child health with that of the paediatric HIV platforms to improve child survival rates and increase the number of children tested for HIV. Within this initiative, there will be a push to screen for HIV in children enrolled in CMAM centres and SAM services programming.

The NutriDash platform has also provided a means for better integration of data on HIV. In 2013, data were collected on HIV testing and referral to HIV services for children receiving treatment for acute malnutrition in order to establish a baseline for the integration of SAM management and HIV services. Four countries – Cambodia, Haiti, Malawi and Zimbabwe – reported data on these indicators. In Cambodia, Haiti and Zimbabwe, all children in SAM treatment who were tested and found to be HIV-positive were referred for treatment. However, the fact that more countries did not report demonstrates the need to strengthen data collection and reporting around this intervention area in order to better guide programme development. In addition, NutriDash reporting showed that only 39 countries (out of the 159 respondent countries) reported monitoring HIV-exposed infant feeding practice at three months. Only four countries – Guyana, Kenya, Ukraine and the United Republic of Tanzania – were able to fill in the total number of HIV-exposed infants who are breastfed at 3 months. At the country level, a UNICEF-led HIV and nutrition bi-directional linkage project in three countries – Malawi, Mozambique and Zimbabwe – showed that it is programmatically feasible to provide ARVs to at least 70 per cent of the HIV-exposed breastfed infants, and to increase the proportion of children in SAM treatment tested for HIV within a few years (from 70 per cent in 2012 to 74 per cent in 2014 in Zimbabwe).[120]

In another country example, Algeria developed a 'National Strategy on the Elimination of Mother-to-Child Transmission of HIV and AIDS', which is now operational in most of the national territory. HIV and AIDS testing and support centres for pregnant women have been put in place and/or revitalized in most regions. For the remaining region, in the South, the Ministry of Health has planned to revitalize the existing network of testing and support centres during the first semester of 2015.

CHALLENGES AND CONSTRAINTS FOR ALL PROGRAMME AREAS IN NUTRITION

UNICEF faces a number of challenges across the different programme areas that potentially constrain progress towards achieving the outcome of the improved and equitable use of **nutritional support and improved nutrition and care practices**. Two key challenges are highlighted.

First, gaps in nutrition data and context-specific knowledge hamper evidence-based decision-making, especially at subnational levels. Although UNICEF, with its partners, has made significant strides to improve the availability, timeliness and quality of nutrition data, more investment is needed. Improving the use of data to inform decision-making, especially to inform programme planning and management, is critical for continuously improving the quality of our programming and maintaining our equity focus. Access to such data and knowledge can also empower rights holders, while enabling duty bearers to make informed decisions and meet obligations. Strengthening national nutrition information systems will be critical to improving our ability to monitor and achieve results in nutrition.

In addition, current systems to capture, synthesize and analyse programme knowledge and share best practices can be strengthened. Limited capacity and systems to learn from experiences hamper the efficient exchange of ideas and knowledge. Improving our knowledge management systems at global, regional, national and subnational levels will help to share knowledge more efficiently and create evidence to guide more effective programming through creating and sharing global knowledge goods.

Second, significant capacity gaps extend across the varied platforms used to deliver high-impact nutrition interventions, in both humanitarian and development contexts. More work is needed to develop national capacities for scaling up nutrition, especially in the treatment of SAM management. To support capacity development and other implementation strategies, more resources are required to provide the necessary guidance, tools and resources to enable this.

Within UNICEF, limited human resource capacity in nutrition, at global, regional and country levels, remains an ongoing challenge to delivering results in the sector. Unpredictable funding in some countries and regions has undermined our capacity to deliver on policy, guidance and country office support. This can be compounded by additional human-resource time needed to respond to large-scale emergencies.

REVENUE

UNICEF is entirely dependent on voluntary contributions. Regular resources are unearmarked, unrestricted funds. The overwhelming majority of these funds are allocated to country programmes on the basis of under-5 mortality rates; gross national income per capita; and child population, which ensures that most resources are spent in the least developed countries. In turn, each country programme invests its share of regular resources in response to the specific context and development priorities of the country concerned. UNICEF revenue also comes from earmarked or other resources, which include, among others, pooled funding modalities such as thematic funding for UNICEF Strategic Plan outcome and cross-cutting areas. Other resources are restricted to a particular programme, geographic area or strategic priority, or to fund emergency response.

Despite a 5 per cent increase in 2014 to US$1,326 million, regular resource contributions have continued to decline as a share of overall revenue since the turn of the new millennium, from 50 per cent to just over 25 per cent. As we look to the post-2015 agenda, being 'Fit for Purpose' to deliver on the draft SDGs and aligned UNICEF Strategic Plan, flexible and predictable other resources are needed to complement a sound level of regular resources. It is only with more flexible resources that UNICEF can:

THE VALUE OF THEMATIC FUNDING (OR+)

While regular resources remain the most flexible contributions for UNICEF, thematic other resources (OR+) are the second-most efficient and effective contributions to the organization and act as ideal complementary funding. Thematic funding is allocated on a needs basis, and allows for longer-term planning and sustainability of programmes. A funding pool has been established for each of the Strategic Plan 2014–2017 outcome areas, as well as for humanitarian action and gender. Resource partners can contribute thematic funding at the global, regional or country levels.

Contributions from all resource partners to the same outcome area are combined into one pooled-fund account with the same duration, which simplifies financial management and reporting for UNICEF. A single annual consolidated narrative and financial report is provided that is the same for all resource partners. Due to reduced administrative costs, thematic contributions are subject to a lower cost recovery rate, to the benefit of UNICEF and resource partners alike. For more information on thematic funding and how it works, please visit *www.unicef.org/publicpartnerships/66662_66851.html*

PARTNER TESTIMONIAL

"Helping children in need is the most important investment that we can make to achieve development, human rights, peace and stability. UNICEF is a key partner in this respect. [...]

The flexibility of UNICEF's thematic funding allows us to reach the most vulnerable children, improve the effectiveness of our response and achieve better results. It also enables us to promote innovation and sustainability, improve coordination and long-term planning, and reduce transaction costs.

In accordance with its mandate, UNICEF works to promote the protection of children's rights and the fulfilment of their basic needs, and to increase children's opportunities so that they can reach their full potential. In today's world, UNICEF's work to fulfil this mandate is more important than ever."

Børge Brende
Minister of Foreign Affairs,
Government of Norway

UNICEF Strategic Plan 2014-17 Thematic Windows:

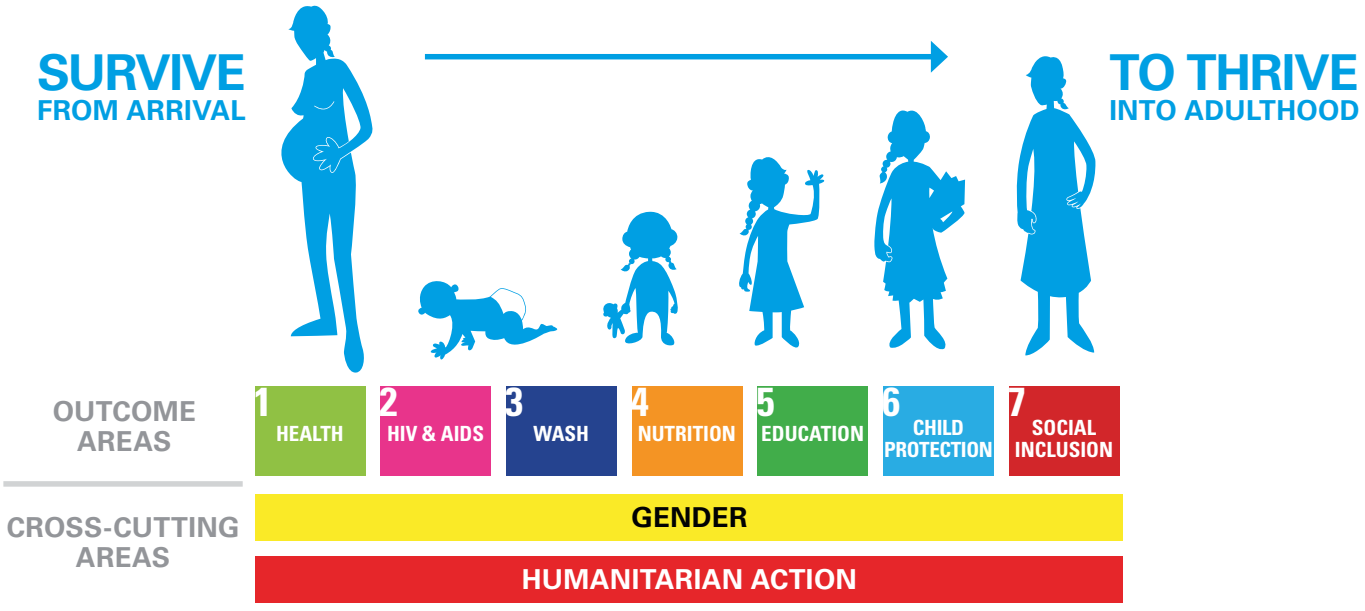
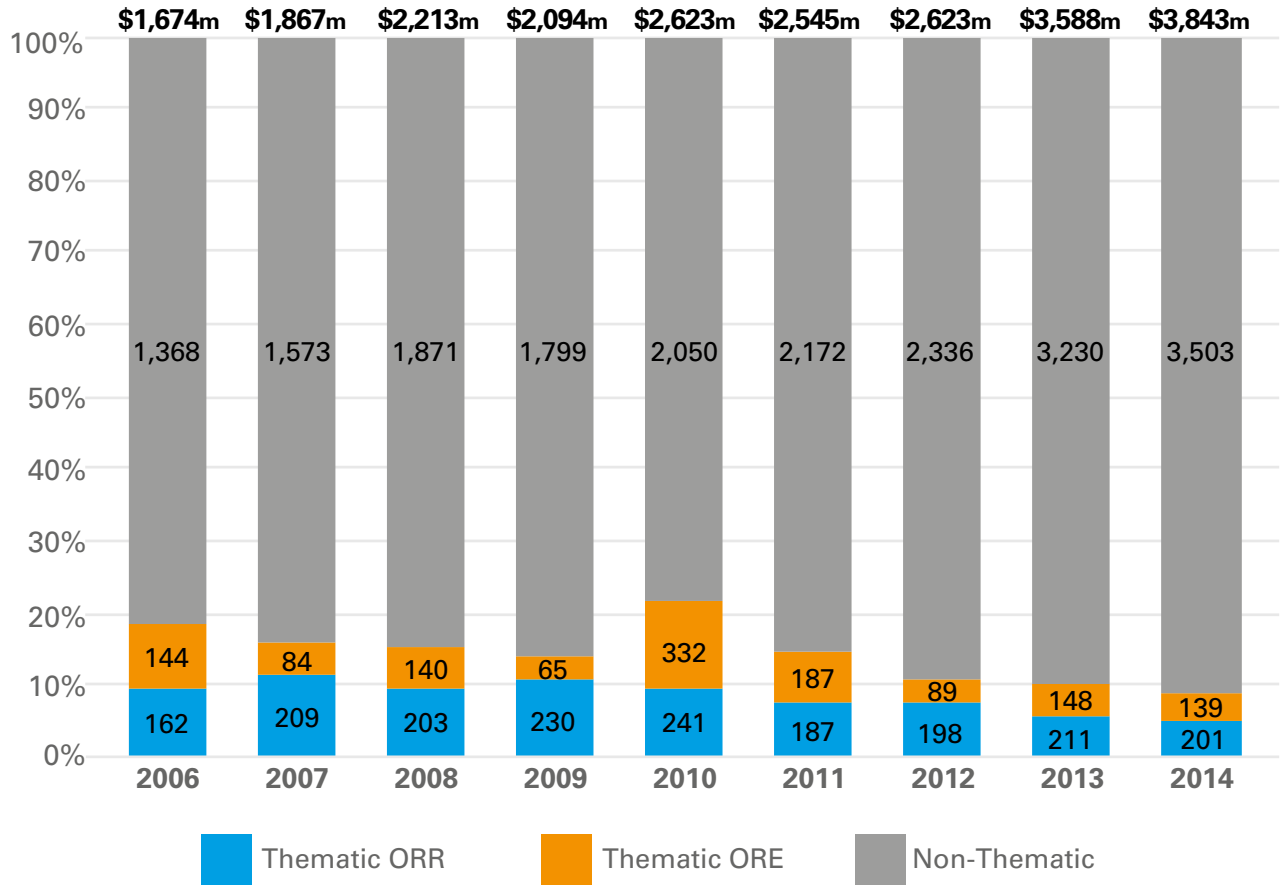


FIGURE 7

OTHER RESOURCE CONTRIBUTIONS 2006–2014: THEMATIC VS. NON-THEMATIC



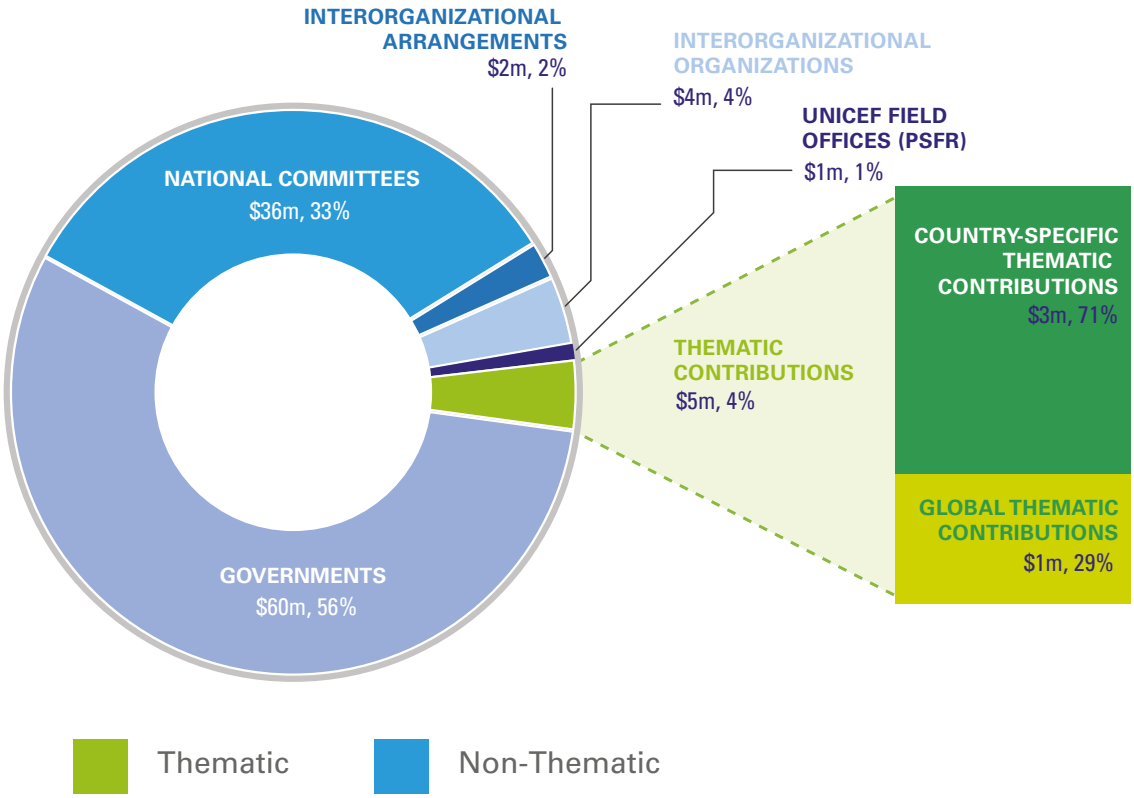
- maintain its independence, neutrality and role as a trusted partner, with adequate and highly skilled capacity at country level, for country-driven, innovative and efficient programming;
- achieve key results for all country programmes of cooperation;
- respond quickly and flexibly to changing circumstances, including sudden-onset emergencies, allowing the channelling of resources to programme areas where they are most needed.

Additional and complementary earmarked funds can then be used to bring solutions to scale in different contexts.

Of the US$5,169 million of UNICEF's revenue in 2014, US$3,843 million were other resources. Of these, US$341 million constituted thematic contributions, marking a 5 per cent decrease from the US$359 million received in 2013. This reflects a continuing decline in thematic funding as a percentage of other resources, from an all-time high of 21 per cent in 2010 to an all-time low of just under 9 per cent in 2014 (*see Figure 7*).

FIGURE 8

OTHER RESOURCES BY FUNDING MODALITY AND PARTNER GROUP, NUTRITION, 2014: $108 MILLION



Of the US$108 million other resources to nutrition in 2014, 96 per cent were highly earmarked funds, mostly from government partners (*see Figure 8*).[121] The remainder were thematic contributions. Of the US$5 million in thematic contributions, only 29 per cent was received at the most flexible global level. Less flexible funding continues to be a challenge for UNICEF and nutrition in particular, as resources and efforts shift to preparing project proposals and reporting for tighter earmarked contributions.

Forty-one per cent of thematic contributions received for the sector came from four government partners (*see Table 1*). Sweden was the largest thematic resource partner to nutrition, contributing just over one quarter of all thematic contributions. These resources were destined at the country level for the Plurinational State of Bolivia and Zimbabwe. The Government of Luxembourg provided its thematic support at the global level.

The National Committees for UNICEF provided 58 per cent of thematic contributions to nutrition, allocated at both the country and global levels.

UNICEF is seeking to broaden and diversify its funding base (including thematic contributions). There were 16 partners that contributed thematic funding to nutrition in 2014, compared with the 34 that contributed to the broader area of young child survival and development in 2013.

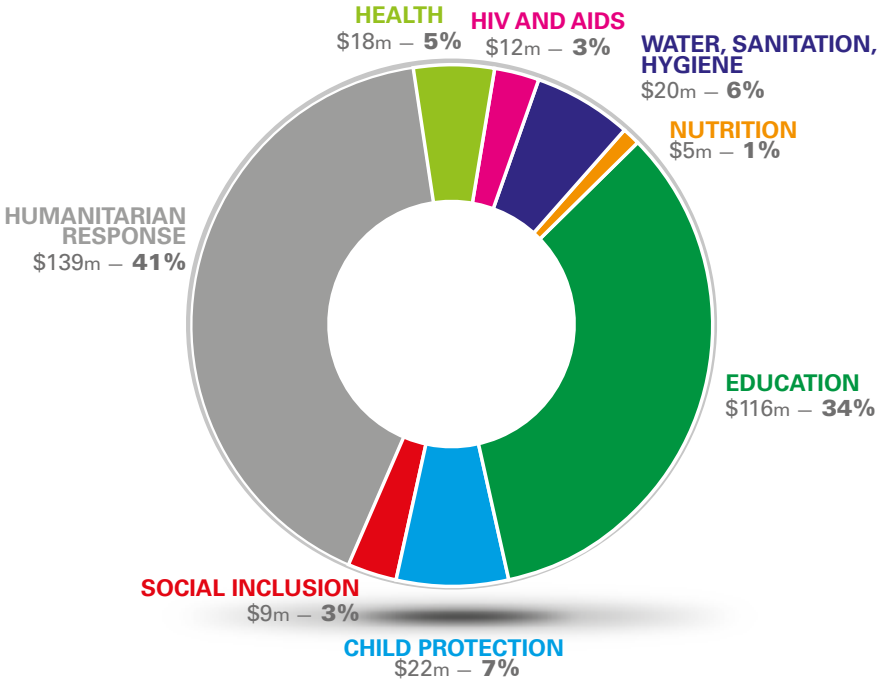
TABLE 1

THEMATIC CONTRIBUTIONS BY RESOURCE PARTNER TO NUTRITION IN 2014

Resource partner type	Resource partner	Amount (in US$)	Percentage
Governments 41%	Sweden	1,190,639	25.55%
	Luxembourg	680,272	14.60%
	Canada	55,291	1.19%
	New Zealand	174	0.00%
National Committees 58%	Netherlands Committee for UNICEF	1,036,603	22.25%
	Korean Committee for UNICEF	400,110	8.59%
	Swiss Committee for UNICEF	387,478	8.32%
	Portuguese Committee for UNICEF	316,915	6.80%
	Norwegian Committee for UNICEF	256,725	5.51%
	Icelandic Committee for UNICEF	78,328	1.68%
	Czech Committee for UNICEF	70,855	1.52%
	Belgian Committee for UNICEF	67,935	1.46%
	United States Fund for UNICEF	46,500	1.00%
	Spanish Committee for UNICEF	35,049	0.75%
	Slovenian Committee for UNICEF	11,371	0.24%
Field Offices PSFR 1%	UNICEF United Arab Emirates	24,976	0.54%
Grand total		**4,659,220**	**100.00%**

FIGURE 9

THEMATIC CONTRIBUTIONS TO STRATEGIC PLAN OUTCOMES AND CROSS-CUTTING AREAS, 2014: $341 MILLION



The decline in thematic funding pools overall, including having received no gender equality thematic contributions (*see Figure 9*), needs to be addressed to fulfil the shared commitment made by UNICEF partners to provide more flexible and pooled funding. In the Quadrennial Comprehensive Policy Review resolution, Member States called for enhanced cost-effectiveness, highlighting pooled funding modalities as a means of achieving this objective. Subsequently, the dialogue on financing the Strategic Plan structured by the UNICEF Executive Board called for partners to enhance the flexibility and predictability of resources aligned to the organization's strategic mandate. Board Members further chose to highlight the importance of thematic funds as an important complement to regular resources for both development and humanitarian programming and the links between the two, in line with UNICEF's universal mandate and in support of country-specific priorities.

FINANCIAL IMPLEMENTATION

Table 2 shows total UNICEF expenses by outcome area, including funding source (*see Table 2*). Nutrition accounts for 11.72 per cent of all total UNICEF expenses in 2014. This expenditure is against 1 per cent of the total thematic funds received for nutrition. This highlights the fact that nutrition expenditures are mostly from emergency and other resources and that the Nutrition Sector would greatly benefit from more thematic fund allocation. Expenses are higher than the income received, as while income reflects only earmarked donor contributions to the specific outcome area in 2014, the expenses are against total allotments including regular resources and other resources (balances carried over from prior years) which are contributing to the same programme outcome area.

Table 3 shows the expenditures on nutrition, by programme area and funding source (*see Table 3*).

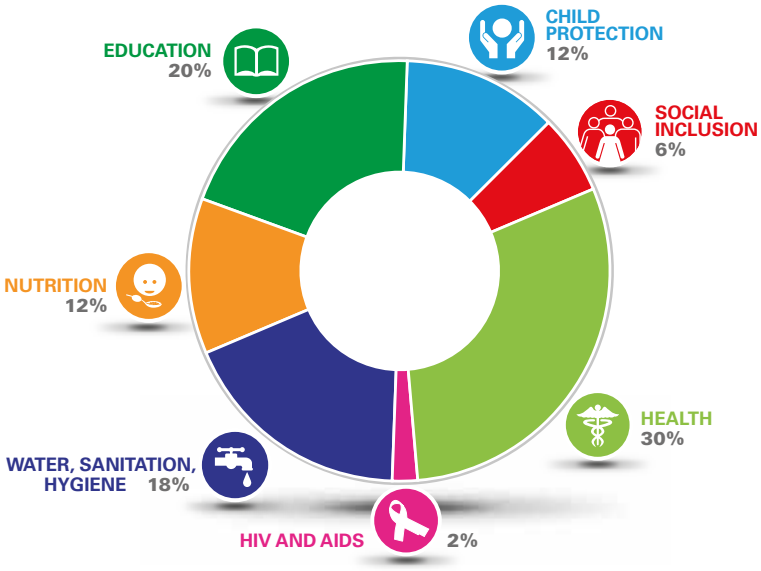
TABLE 2

TOTAL UNICEF EXPENSES BY STRATEGIC PLAN OUTCOME AREA AND FUNDING SOURCE, 2014

Outcome area	Other resources (emergency)	Other resources (regular)	Regular resources	Grand total
Health	250,129,359	729,517,594	249,330,250	1,228,977,204
HIV and AIDS	4,030,935	65,633,899	37,451,004	107,115,838
WASH	349,811,171	276,212,322	101,344,461	727,367,953
Nutrition	**245,138,305**	**173,477,324**	**65,561,501**	**484,177,129**
Education	182,614,274	508,003,766	135,605,237	826,223,276
Child protection	150,462,660	218,019,161	145,870,856	514,352,677
Social inclusion	21,112,189	96,414,231	125,071,950	242,598,370
Grand total	**1,203,298,893**	**2,067,278,296**	**860,235,259**	**4,130,812,447**

FIGURE 10

UNICEF EXPENDITURE BY OUTCOME AREA, 2014



Source: UNICEF strategic plan cube March 2015.

TABLE 3

EXPENDITURE ON NUTRITION BY PROGRAMME AREA, 2014

Programme area	Other resources (emergency)	Other resources (regular)	Regular resources	Grand total	% To total
Infant and young child feeding	15,429,864	29,185,759	11,755,271	56,370,895	12%
Micronutrients	8,718,517	26,896,676	4,070,424	39,685,616	8%
Nutrition and HIV	9,979	98,176	334	108,490	0%
Community-based management of acute malnutrition	69,760,267	38,040,345	10,285,012	118,085,624	24%
Nutrition and emergencies	43,669,264	19,787,140	7,720,263	71,176,666	15%
Nutrition – general	107,550,414	59,469,228	31,730,197	198,749,838	41%
Grand total	**245,138,305**	**173,477,324**	**65,561,501**	**484,177,129**	**100%**

General nutrition activities account for more than 40 per cent of all expenses for the sector. This is a good reflection of the work that UNICEF is doing to support countries that use evidence-based nutrition strategies and advocate for the development of capacities to ensure that nutrition commitments are translated into policies and programmes. The work around linking nutrition and HIV and providing nutritional support to HIV-infected communities needs to be strengthened and further developed. It should be noted that because of the interlinked nature of interventions in country programme settings, the category of general nutrition activities may include some of the more specific interventions (e.g., the link between IYCF and micronutrients), and is therefore not a completely reliable reflection of expenditures on policy and programme development alone.

Of total other resources (regular) spent, thematic and non-thematic expenditure accounted for 3 per cent and 97 per cent, respectively (*see Table 4*). The highest level of thematic funds for nutrition was spent in Eastern and Southern Africa, followed by East Asia and the Pacific.

TABLE 4

OTHER RESOURCES REGULAR EXPENDITURE ON NUTRITION, BY THEMATIC AND NON-THEMATIC FUNDING, 2014

Region	Thematic	Non-thematic	Total ORR
CEE/CIS	93,151	1,681,111	1,774,261
EAPR	1,230,834	5,513,826	6,744,660
ESAR	1,696,985	61,935,814	63,632,799
HQ	347,798	2,774,070	3,121,868
LACR	680,801	1,142,606	1,823,407
MENA	485,886	13,868,906	14,354,792
ROSA	495,647	10,335,744	10,831,390
WCAR	702,598	70,491,548	71,194,146
Grand Total	**5,733,699**	**167,743,624**	**173,477,324**

TABLE 5

EXPENDITURE ON NUTRITION, BY REGION AND FUNDING SOURCE, 2014

Region	Other resources (emergency)	Other resources (regular)	Regular resources	Grand total
CEE/CIS	39,346	1,774,261	1,242,196	3,055,804
EAPR	9,729,378	6,744,660	5,957,147	22,431,185
ESAR	60,191,114	63,632,799	17,367,033	141,190,946
Headquarters	1,444,509	3,121,868	1,413,230	5,979,606
LACR	3,512,552	1,823,407	2,118,846	7,454,806
MENA	45,840,142	14,354,792	3,782,065	63,977,000
ROSA	30,872,823	10,831,390	12,952,502	54,656,715
WCAR	93,508,440	71,194,146	20,728,481	185,431,067
Grand total	**245,138,305**	**173,477,324**	**65,561,501**	**484,177,129**

RETIONAL AND COUNTRY ACTIVITIES

Table 5 shows the nutrition outcome area expenses by region and funding source (*see Table 5*). Two regions stand out with 38 per cent and 29 per cent of the total expenses in the WCA and ESA regions. These two regions received a substantial amount of funding (see the expenses list of the top 10 countries) and were affected by many emergency and humanitarian crises in 2014. *Table 6* and *Table 7* show outcome area expenses by country.

TABLE 6

TOP 10 COUNTRY OFFICES BY TOTAL EXPENDITURE ON NUTRITION, 2014

Country Office	Expenditure US$ (millions)
Ethiopia	44
Nigeria	31
Somalia	30
Niger	30
Mali	28

Country Office	Expenditure US$ (millions)
Yemen	27
Sudan	25
Democratic Republic of the Congo	19
Pakistan	17
Kenya	16

TABLE 7

TOP 10 COUNTRY OFFICES BY EXPENDITURE FROM EMERGENCY AND NON-EMERGENCY FUNDS FOR NUTRITION, 2014

Non-emergency funds	
Country office	**Expenditure US$ (millions)**
Ethiopia	31
Nigeria	29
Yemen	12
Mali	12
India	10
Niger	9
Democratic Republic of the Congo	8
Somalia	7
Burkina Faso	6
Republic of Mozambique	6

Emergency funds	
Country office	**Expenditure US$ (millions)**
Somalia	23
Niger	20
Sudan	19
Mali	16
Yemen	15
Pakistan	14
Chad	14
Ethiopia	13
Afghanistan	13
Kenya	12

Emergency funds = ORE **Non-emergency = ORR and RR (including EPF)**

FUTURE WORKPLAN

At only one year into the 2014-2017 Strategic Plan, UNICEF has already made **important progress towards the goal of improved and equitable use of nutrition support and improved nutrition and care practices**. Many countries have improved coverage rates of key micronutrient interventions such as VAS and iodized salt. Others have seen an increase in rates of exclusive breastfeeding and better IYCF counselling and support for caregivers. At the global level, UNICEF's guidance on scaling up nutrition programming for mothers and their children provides countries with the tools they need to apply a more rigorous approach to results-based nutrition programming at scale, and UNICEF will continue to support countries to reach more children and women with effective interventions.

In 2015, UNICEF will ensure that lessons learned from the first year of this Strategic Plan are translated into concrete applications for the year ahead. In fact, this has already been an iterative and ongoing process in nutrition. For example, the recommendations and lessons learned from the 2014 meta-evaluation of UNICEF nutrition programmes have already informed the guidance on scaling up such programmes. In 2015, attention will turn towards operationalizing the guidance to ensure that those recommendations continue to support a continuous improvement in nutrition programming, focusing on the most disadvantaged.

In 2015, the strengthening of country and global nutrition data collection will remain a priority, in addition to supporting global initiatives, such as the Global Nutrition Report, which will be produced annually. UNICEF will work to: 1) strengthen national nutrition information systems; 2) support innovations in real-time monitoring; and 3) fill gaps in programme data. The NutriDash portal provides an opportunity to address important data gaps at national and global levels and has attracted interest from donors and partners. Based on the results and recommendations of the pilot year, the Nutrition Sector will work to simplify data entry, further optimize outputs to meet country office needs, harmonize processes with ongoing data collection and improve linkages to supply and programme management.

Over the past year, the Nutrition Sector was faced with a number of unexpected but critical events and humanitarian situations to which it adapted and responded. In 2015, UNICEF will aim to respond better to such events, through improved, flexible response mechanisms and stronger human resource capacity.

In the coming year, UNICEF will aim to further define its approach to emerging issues in nutrition, for example its stance on overweight and obesity prevention in countries where it coexists with stunting and other nutritional deficiencies. UNICEF will also further expand and improve quality of treatment of SAM, including the use of innovative technologies to improve efficiency of approaches, programme quality and accountability to affected populations. The Nutrition Sector will also aim to strengthen linkages with other sectors, in particular with WASH.

In 2015, UNICEF will support global efforts to ensure that nutrition is well positioned in the post-2015 agenda. This includes active participation in innovative global financial initiatives for nutrition, including Power of Nutrition.

UNITLIFE is a proposed funding mechanism using revenues from the extractive industries sector to fight stunting and other forms of malnutrition in sub-Saharan Africa. The innovative initiative taps into these resource flows through national-level micro-levies on oil and other commodities to finance nutrition-focused interventions in the continent. The initiative is expected to generate several other benefits for African children. These include (i) crowding-in of additional non official development assistance (ODA) sources, and (ii) improving domestic policy frameworks for nutrition and other child-focused interventions in sub-Saharan Africa.

UNICEF is partnering with Power of Nutrition, a new catalytic financing facility for nutrition that aims to unlock up to US$1 billion in new private and public financing to support countries in scaling up high-impact programming. The facility will multiply the financial resources going into this area, through a combination of grants, government funding and World Bank International Development Association (IDA) financing. Earmarked nutrition funding to UNICEF will be matched dollar per dollar by Power of Nutrition, thereby doubling nutrition funding to the selected programme at the country level.

UNICEF will galvanize global, regional and national stakeholder support for breastfeeding through its lead role in the Breastfeeding Advocacy Initiative. In addition, UNICEF will continue to support global multi-stakeholder initiatives, such as the SUN movement, to ensure that national governments are better able to respond to the nutritional needs of vulnerable populations. UNICEF will also continue to collaborate with a wide array of partners including UN agencies, international and national NGOs, academic institutions, civil society and private sector, to advocate for and support the scale up of nutrition programmes.

Despite important progress in 2014, nutrition continues to be a neglected area when it comes to resources and funding. Over the course of the Strategic Plan, UNICEF will seek to mobilize US$1.481 billion for its work for children and nutrition. A continuous and flexible funding stream is required in order for UNICEF to maintain its leadership position and deliver results. Although the organization has doubled its expenditure in recent years there is still work to be done in mobilizing funds to achieve the Strategic Plan objectives. Increased flexible resources will be crucial in order to address critical funding gaps and ensure timely humanitarian response.

EXPRESSION OF THANKS

UNICEF wishes to acknowledge all government donors and National Committees that contributed to the work of the nutrition programme. More specifically, an expression of thanks goes to the Governments of Sweden and Luxembourg and the National Committee of the Netherlands.

ABBREVIATIONS AND ACRONYMS

ACF Action Contre la Faim (Action Against Humger)
ARV Antiretroviral Drug
CBO Community-based Organization
CCC Core Commitments for Children
CDC United States Centers for Disease Control and Prevention
CMAM Community Management of Acute Malnutrition
DHS Demographic and Health Surveys
ENN Emergency Nutrition Network
ESARO East and South Africa Regional Office
FAO Food and Agricultural Organization of the United Nations
FFI Food Fortification Initiative
GAIN Global Alliance for Improved Nutrition
GAVA Global Alliance for Vitamin A
HF-TAG Home Fortification Technical Advisory Group
HKI Helen Keller International
IDD Iodine Deficiency Disorders
IYCF Infant and Young Child Feeding
MAM Moderate Acute Malnutrition
MENA Middle East and North Africa Region
MI Micronutrient Initiative
MICS Multiple Inicator Cluster Surveys
MoRES Monitoring Results for Equity System
NGO Non-Government Organization
REACH Renewed Efforts Against Child Hunger
RRM Rapid Response Mechanism
RUIF Ready-to-Use Infant Food
RUTF Ready-to-Use Therapeutic Foods
SAM Severe Acute Malnutrition
SDG Sustainable Development Goals
SMQ Strategic Monitoring Questions
SUN Scaling Up Nutrition
USAID United States Agency for International Development
USI Universal Salt Iodization
VAS Vitamin A Supplementation
WASH Water, Sanitation and Hygiene
WHA World Health Assembly
WHO World Health Organization

END NOTES

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END NOTES (continued)

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ANNEX

Impact and Outcome Indicators

Indicators	Baseline	2017 Target	2014 update or data from most recent year
4a. Number of children under 5 years who are moderately and severely stunted	169 †† million (2010)	approx. 100 million (2022)	161 million (2013)
4b. Percentage of women of reproductive age with anaemia	38% †† pregnant, 29% †† non-pregnant (1995–2011)	TBD	Updated data not available
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	30 out of 104 UNICEF programme countries with data (2007–2013)
P4.2 Countries with at least 90% of households consuming adequately iodized salt	6 (2007–2013)	40	5 out of 61 UNICEF programme countries with data (2007–2013)
P4.3 Countries with at least 80% of primary caregivers engaged in early childhood stimulation for 3–5 year olds (36–59 months) at home ‡	16† (2005–2013)	50	19 out of 55 UNICEF programme countries with data (2006–2014)
P4.4 Countries with at least 90% of children 6–59 months covered with 2 annual doses of Vitamin A supplements	22/69 (2011–2012)	44	27 out of 61 Vitamin A supplements priority countries with data (2013)
P4.5 Number and percentage of children between 6–59 months affected by SAM reached with quality treatment, defined as children who recovered (report separately for humanitarian situations) ‡	2,662,712 admissions (2012) 85% recovered (2012)	TBD	2,909,410 admissions (2013) 82% recovered (2013)

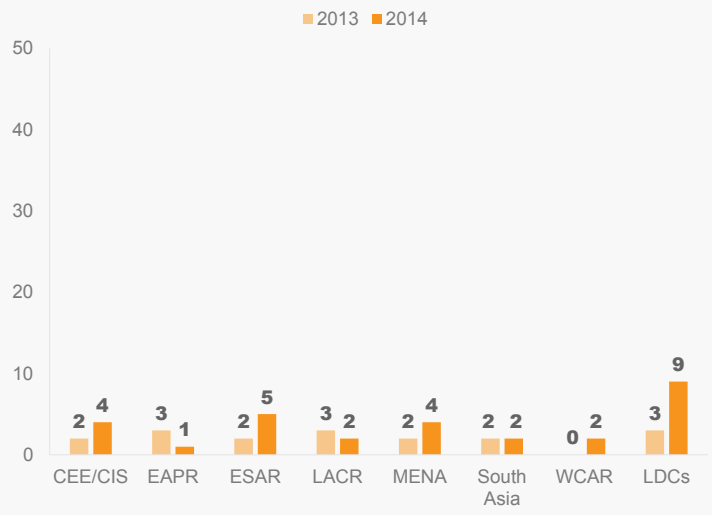
Output Indicators

P4.a.1

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

Baseline † 14 **2014 update** 20

2017 Target 40



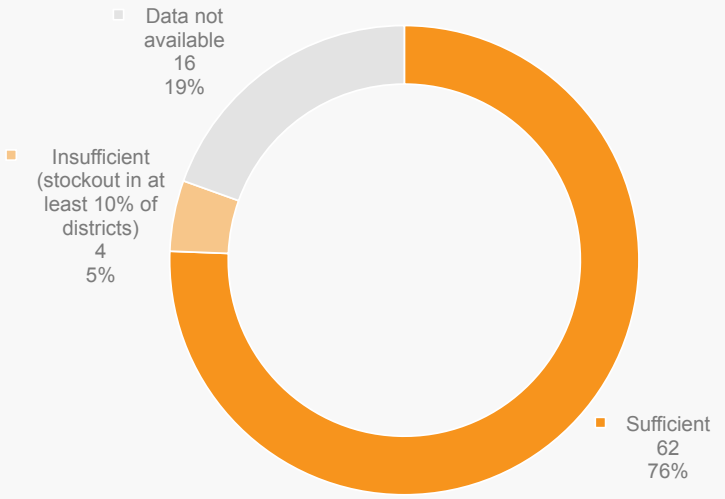
Source: UNICEF country offices, 2014.

P4.b.1

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

Baseline 72 **2013 update** 62

2017 Target 82



Note: Only VAS priority countries are included.

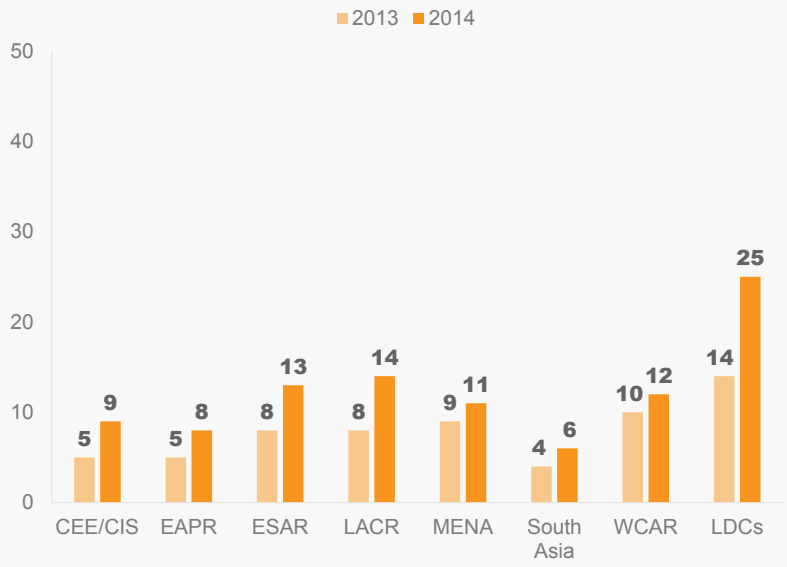
Source: UNICEF Headquarters, 2015

P4.c.1

Countries where the International Code on Marketing of Breastmilk substitutes is adopted as legislation and monitored ‡

Baseline † 49 **2014 update** 73

2017 Target 72

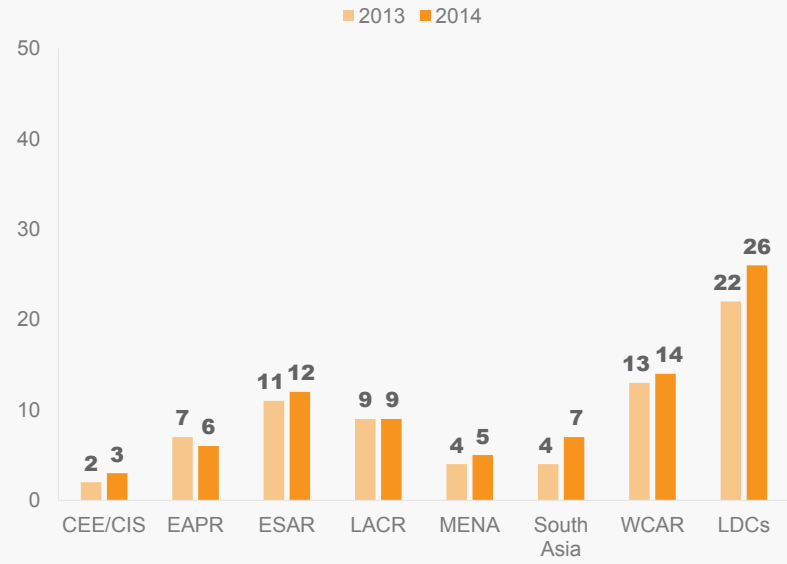


P4.c.3

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

Baseline † 50 **2014 update** 56

2017 Target 70



Source: UNICEF country offices, 2014.

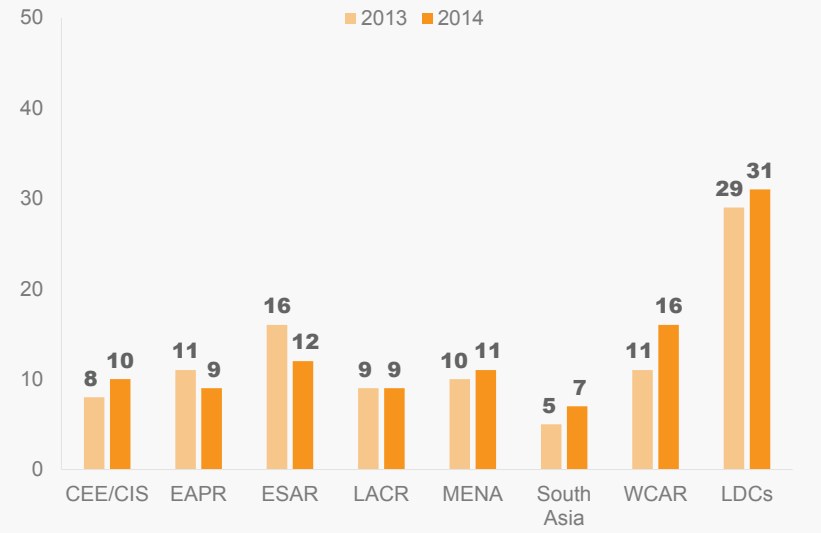
P4.c.2

Countries with a policy or plan targeting anaemia reduction in women and girls

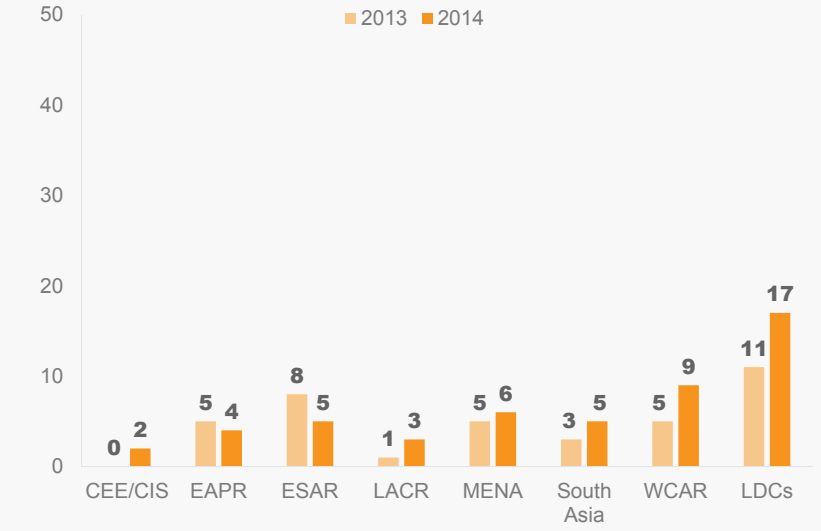
Baseline †
Women: 70
Girls: 27

2014 update
Women: 74
Girls: 34

2017 Target
Women: 100
Girls: 50



Women



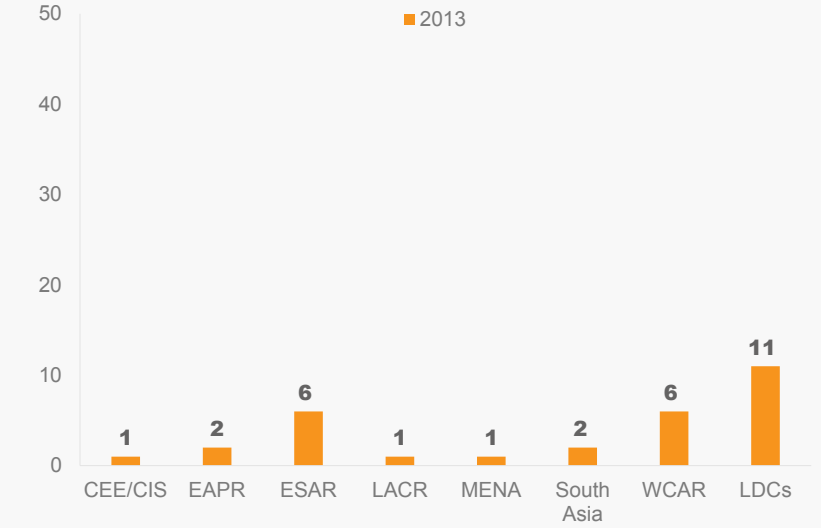
Girls

Source: UNICEF country offices, 2014.

SPPL.

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

2013 19



Source: UNICEF Headquarters, 2015.

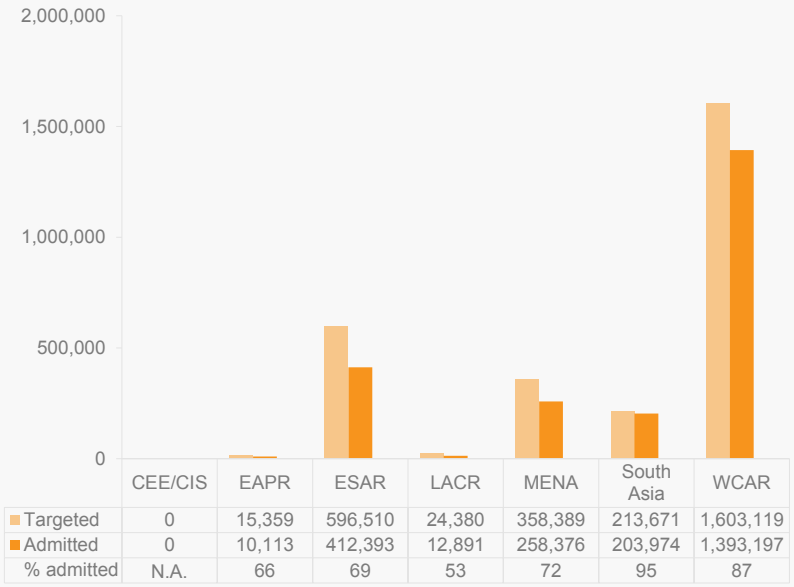
P4.d.1

Number and percentage of UNICEF targeted children aged 6–59 months with severe acute malnutrition in humanitarian situations are admitted to programmes for management of acute malnutrition and recovery

Baseline
Recovery rate > 75%

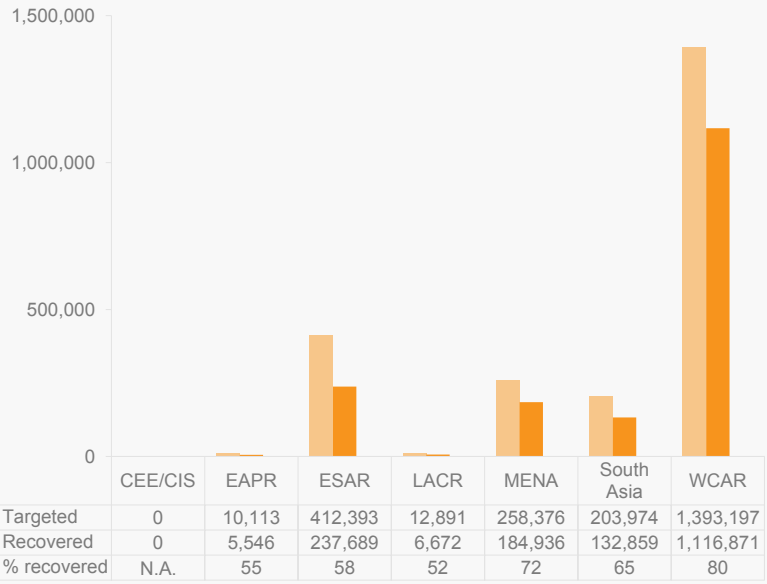
2014 update
Admitted:
2,290,944 (admitted);
2,811,428 (targeted)
85.5%
Recovered:
1,684,573 (recovered);
2,290,944 (admitted)
73.5%

2017 Target
Recovery rate > 75%



	CEE/CIS	EAPR	ESAR	LACR	MENA	South Asia	WCAR
Targeted	0	15,359	596,510	24,380	358,389	213,671	1,603,119
Admitted	0	10,113	412,393	12,891	258,376	203,974	1,393,197
% admitted	N.A.	66	69	53	72	95	87

Admitted



	CEE/CIS	EAPR	ESAR	LACR	MENA	South Asia	WCAR
Targeted	0	10,113	412,393	12,891	258,376	203,974	1,393,197
Recovered	0	5,546	237,689	6,672	184,936	132,859	1,116,871
% recovered	N.A.	55	58	52	72	65	80

Recovered

Note: Targeted (for 'Recovered'): Children (aged 6–59 months) with severe acute malnutrition in humanitarian situations who are admitted to programmes

Source: UNICEF country offices, 2014.

42

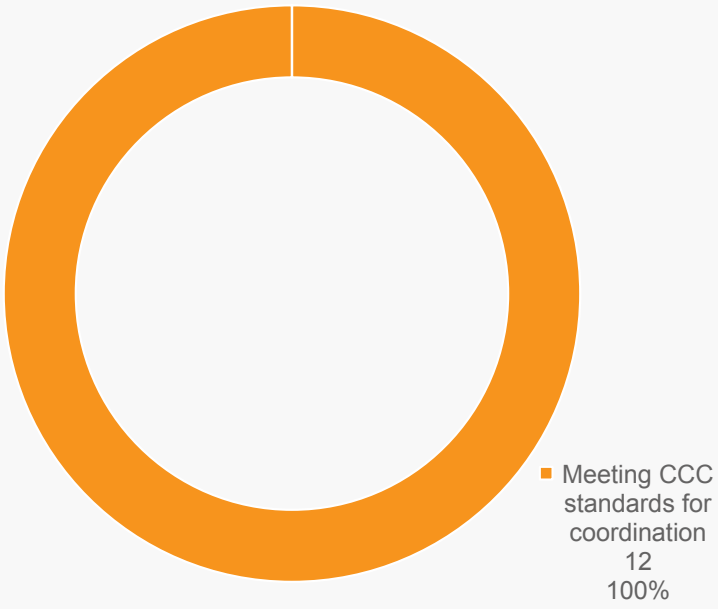
P4.d.2

Countries in humanitarian action where country cluster or sector coordination mechanism for Nutrition meet CCC standards for coordination

Baseline 20

2014 update
12 countries (100% of Nutrition Cluster countries)

2017 Target 100%



Note: Core Commitments for Children in Humanitarian Action standards for coordination defined as: convening partners; establishing terms of reference for coordination; establishing cluster operational strategy/action plan; performance management system in place; sector coverage known from cluster reporting.

Source: UNICEF Headquarters, 2014.

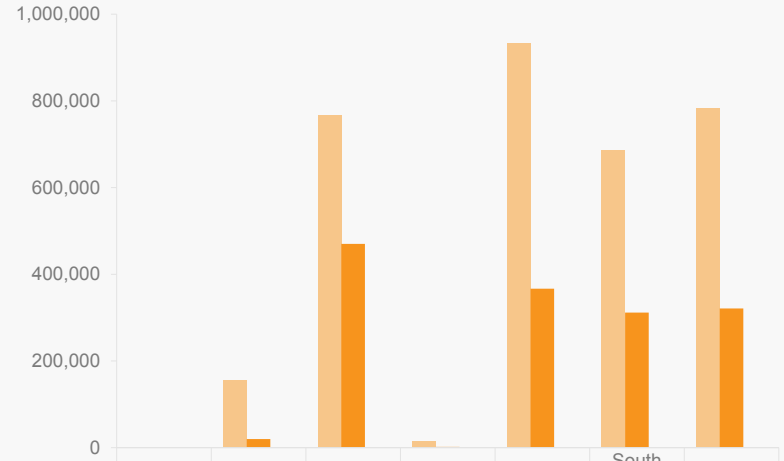
P4.d.3

Number and percentage of 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 ‡

Baseline † / 2014 update
1,491,211
(received EC stimulation and development);

3,339,415
(received IYCF counselling or group education session on IYCF); 44.7%

2017 Target TBD



	CEE/CIS	EAPR	ESAR	LACR	MENA	South Asia	WCAR
Targeted	0	154,677	766,173	15,144	934,111	685,514	783,796
Reached	0	20,030	469,985	1,769	366,718	311,545	321,164
% reached	N.A.	13	61	12	39	45	41

Note:
Targeted: Caregivers who received IYCF counselling or attended a group education session on IYCF.
Reached: Caregivers who also received the promotion of early childhood stimulation and development as part of IYCF.

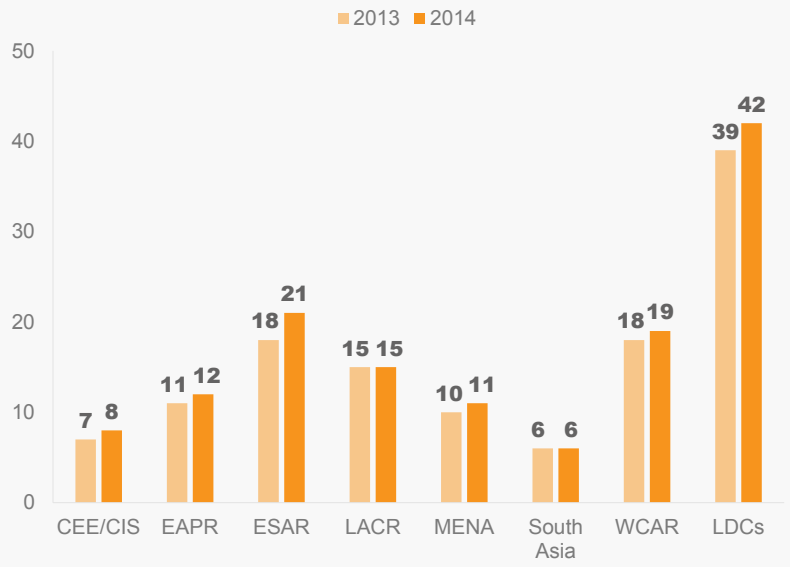
Source: UNICEF country offices, 2014.

P4.e.1

Countries with national management information systems that disaggregated data on nutrition

Baseline † 85 **2014 update** 92

2017 Target 100

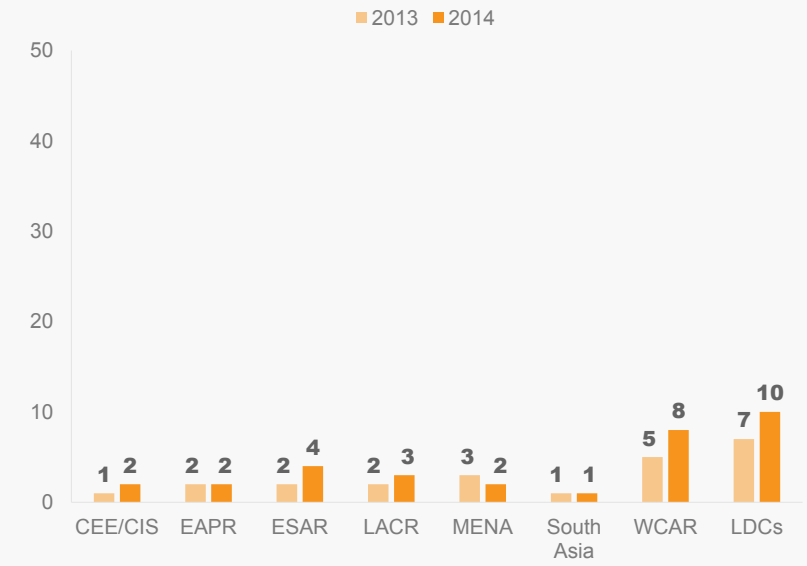


P4.e.2

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

Baseline † 16 **2014 update** 22

2017 Target 40



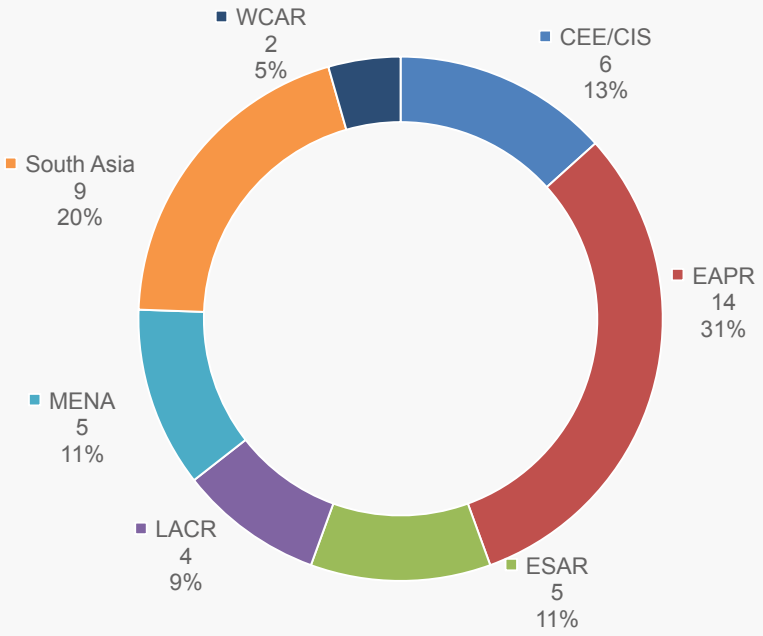
Source: UNICEF country offices, 2014.

P4.f.1

Number of peer-reviewed journals or research publications by UNICEF on nutrition in children and women

Baseline †/ 2014 update 45

2017 Target 20



Note: Data reflect number of papers that UNICEF country offices have authored or co-authored in peer-reviewed journal in 2014.

P4.f.2

Number of key global and regional Nutrition initiatives in which UNICEF is the co-chair or provides coordination support

Baseline 6 **2014 update** 9

2017 Target 10

Global initiatives

- Breastfeeding Advocacy
- Global Alliance for Improved Nutrition (GAIN)
- Global Nutrition Cluster (GNC)
- Home Fortification Technical Advisory Group (HFTAG)
- Infant and Young Child Feeding in Emergencies (IFE) Core Group
- The Micronutrient Forum
- Scaling Up Nutrition (SUN)
- UN Network [Renewed Efforts Against Child Hunger (REACH)/Standing Committee on Nutrition (SCN)]
- US Nutrition partners

Source: UNICEF country offices, 2014.

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